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RECOMMENDATION FOR SUPPLEMENTARY FUNDING FOR PROGRAMMES IN THE
EASTERN AND SOUTHERN AFRICA REGION WITHOUT RECOMMENDATIONS FOR
FUNDING FROM GENERAL RESOURCES

SUMMARY

The present document contains recommendations for supplementary funding in countries in the Eastern and Southern Africa region for which no recommendations for funding for general resources are requested at the 1990 Executive Board session. The project proposals submitted here are aimed at expanding or complementing ongoing programmes in the countries concerned. The Executive Director recommends that the Executive Board approve supplementary funding in the following amounts for the projects listed below, subject to the availability of specific-purpose contributions.

<u>Country/programme</u>	<u>Amount</u> (United States dollars)	<u>Duration</u>
Angola	6 465 000	1990-1991
Ethiopia	30 337 300	1990-1992
Malawi	7 000 000	1990-1992
United Republic of Tanzania	28 519 200	1990-1992
Zimbabwe	750 000	1990-1991

Summaries of the individual recommendations follow. A table setting out the planned annual phasing of expenditure for each supplementary funding proposal is given at the end of the document.

I. ANGOLA

U5MR: 292

IMR: 172

GNP per capita: \$470

Child population (0-15 years): 4.2 million

Literacy rate (male/female): 49/33 per cent

Access to health services: 30 per cent

The situation of children and women

1. Despite recent peace initiatives, Angola remains in a state of war and social disruption. This has created an environment hostile to child survival. Infant mortality rates (IMR) are high and rising, and literacy rates are falling as essential health and education services are sacrificed in favour of defence. In many areas, basic primary health care/maternal and child health (PHC/MCH) services have been undermined by the destruction of facilities and shortages of staff, essential drugs, basic equipment and supervisory services. Vaccination coverage is low, as is access to curative and MCH services. Public health standards have dropped as water supplies have been sabotaged or have broken down. War and rural insecurity have fuelled massive population displacement. By mid-1989, it was estimated that over 1.5 million people (17 per cent of the total population) were severely affected. Child mortality rates - largely attributable to diarrhoea, malaria, immunizable diseases, respiratory infections and malnutrition - are between 200 to 300 per 1,000 live births. Rates of malnutrition and associated mortality are also high. Among children under five years old, recent surveys indicated severe malnutrition ranging from 5 to 10 per cent and moderate malnutrition from between 25 and 40 per cent. With increased physical burdens and psychological strains, maternal nutritional status has deteriorated, and growing fertility rates (as a reaction to reduced rates of child survival) are fuelling maternal depletion. The result has been increased maternal mortality, low birth weight, delivery complications, neonatal deaths (especially attributable to tetanus) and spontaneous abortions, and an increased number of weakened mothers unable to care for themselves and their children.

2. Despite the considerable constraints to programme planning and implementation during the previous programme of co-operation (1987-1989), progress has been achieved in expanding and improving the delivery of PHC services. Following more than five years of sluggish growth in immunization coverage, 1988-1989 witnessed accelerated activity. Ministry of Health statistics indicate a 12 to 23 per cent increase in vaccinations for the 1987-1988 period. The surveys confirmed in the capital city of Luanda a doubling in antigen coverage and a tripling of the proportion of children fully immunized over the past two years - 40.4 per cent with anti-tuberculosis vaccines, 29 per cent with three doses each of combined diphtheria/pertussis/tetanus vaccine and oral polio vaccine, 28 per cent for measles and 70 per cent for tetanus toxoid. Coverage levels in other urban centres of Angola have also increased. Information on rural areas is not available owing to their insecurity.

3. Diarrhoeal diseases remain the single most serious threat to young child growth and survival in Angola. The 1987 national control of diarrhoeal diseases (CDD) evaluation revealed that 82 per cent of mothers recognized packets

of oral rehydration salts (ORS), 69 per cent could prepare ORS solutions correctly and 72 per cent gave more fluids during an episode of diarrhoea. The Ministry of Health estimates that, in Luanda, infant mortality attributable to diarrhoeal diseases has been halved over the past four years. However, it is important to note the limited national expansion of the programme. Since 1983, only 140 clinics (about 15 per cent) have been adequately equipped to provide oral rehydration therapy (ORT); only 10 per cent of health staff have been adequately trained in correct case management; a considerable proportion of mothers are still using anti-diarrhoeal drugs; logistical difficulties continue to restrict ORS availability; and little attention has been paid to developing effective communications strategies on breast-feeding, continued feeding during illness and personal and domestic hygiene.

4. Since 1987, UNICEF has supported the essential drugs programme. At the end of 1988, efforts were made to strengthen and further integrate UNICEF support with that of other donors. The contents of drugs kits and training approaches have been standardized, and six priority districts were selected on the basis of population size, logistics and supervisory accessibility. Despite high levels of severe and moderate malnutrition throughout Angola, nutrition rehabilitation, surveillance and growth monitoring and promotion remain chronically underdeveloped. A survey conducted in 1989 indicated that in Luanda only 42 per cent of children had growth cards and only 19 per cent of children had attended more than two growth monitoring and promotion sessions. In other urban centres, coverage indicators were significantly lower, which suggests that, in accessible rural areas, growth monitoring and promotion coverage would be less than 10 per cent.

Primary health care

5. This programme will extend the PHC programme approved by the Executive Board in 1987 (E/ICEF/1987/P/L.7) for two more years. The programme comprises two integrated and mutually reinforcing components - health and nutrition - and incorporates projects to reinforce immunization, essential drugs, CDD, young child growth monitoring and promotion, nutrition rehabilitation and surveillance activities.

6. The overall goal of the programme of co-operation is to reduce 1980 young child and maternal mortality rates by 50 per cent by the year 2000. This represents a reduction of IMR from 200 to 100 per 1,000 live births; under-five mortality from 300 to 150 per 1,000 live births; and maternal mortality from 620 to 310 per 100,000 live births. To achieve these objectives, the country programme must be reinforced with a PHC programme including an expanded programme on immunization, CDD, essential drugs, and nutrition/growth monitoring. Programme implementation will require national capacity-building through training and technical assistance to planning, management, logistics and operations; community education and social mobilization to promote child care skills and community use of health services; and an area focus on the most populous and/or severely affected provinces.

Expanded programme on immunization

7. Continuing rural insecurity and inaccessibility, burgeoning urban and displaced populations and relatively poor growth in immunization coverage over the past decade have caused the Government to refine its universal child immunization (UCI) by 1990 objectives which were set for 80 per cent coverage in provincial capitals (30 per cent of the total population) and 40 per cent coverage for rural areas under government control. To achieve those objectives, priority attention is being focused on urban immunization acceleration; universal coverage in displaced people's camps; re-establishment of immunization services in the accessible provinces; and support to immunization services as rural areas are liberated.

8. The urban immunization campaign, launched in June 1989, will cover 18 provincial capitals during 1989-1991. Priority attention will focus on the eight most populous cities during 1989-1990. Assistance will ensure that all children are fully immunized in those provinces in which the majority of the rural displaced population are concentrated: Benguela, Huambo, Bie and Kwanza Sul. Attention will focus on the orientation and training of primary schoolteachers, extension workers, party cadres, traditional leaders and community health workers in EPI mobilization, ORT and basic child care. To support these strategies, national capacities will be strengthened in the areas of management; planning; evaluation and epidemiological surveillance services; health education; supply planning; logistics and vehicle management systems. Collaboration with the party and other mass organizations will also be strengthened.

Control of diarrhoeal diseases

9. The primary objectives of the CDD programme are to reduce diarrhoea mortality among children under five years old by 25 per cent and diarrhoea morbidity by 10 per cent by the year 2000. These objectives are to be achieved through correct case management of diarrhoeal illness and preventive strategies designed to reduce the incidence and prevalence of diarrhoeal diseases. To increase access to correct case management, attention will be directed towards establishing a diarrhoea treatment and training unit in each province; ensuring that all provincial-level health staff are trained in CDD management and training techniques; providing annual training for 70 per cent of health clinic staff; providing adequate stocks of ORS; and increasing the number of equipped ORT units from 360 to 500 by 1992. Support will continue for community education and mobilization to increase child caretakers' awareness of ORS from 80 to 90 per cent and use from 65 to 85 per cent.

10. While activities to promote access, awareness and use of ORT and correct case management will be implemented nationally, preventive activities in the provinces of Huila, Benguela, Kwanza Sul and Bengo will promote exclusive breast-feeding and improved young child feeding, immunization and personal and domestic hygiene. Education materials will be developed for health staff and community members.

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Essential drugs programme

11. This component is critical to the success of the overall child survival and development (CSD) strategy. By ensuring the availability and correct use of essential drugs, unnecessary deaths will be averted and community confidence in MCH/FHC services can be restored. Seven provinces now receive assistance under the national essential drugs programme. Plans are being prepared to expand the programme to an additional 100 clinics. The project will include the supply of approximately 1,000 essential drugs kits; the training of 200 clinic health workers in essential drugs therapy and management; the training of 30 provincial-level health managers, supervisors and logisticians; the continued development of training and health education materials; the rehabilitation of national- and provincial-level essential drugs and equipment stores; the strengthening of logistics planning and management systems; and the establishment of a system to monitor existing drugs kits and therapeutic guidelines. In addition, an operational research project will determine the potential for introducing community financing and/or cost-recovery approaches to sustain basic health services.

Integrated child nutrition programme

12. In an effort to reduce high rates of young child malnutrition, the programme has focused on growth monitoring and promotion, nutrition rehabilitation services and the establishment of a nutrition surveillance system. For the extended programme, priority attention will focus on strengthening growth monitoring and promotion services in four cities and a limited number of health centres in Namibe, Huila, Cunene and Kwanza Sul provinces. UNICEF will revise and reprint the growth monitoring guide; support provincial- and district-level growth monitoring and promotion training activities; produce and distribute growth charts and provide weighing scales. In addition, a series of surveys will be undertaken to assist in the development of communications strategies and counselling materials.

13. Nutrition rehabilitation services, currently being provided through 20 provincial-level units, will be strengthened and expanded to rehabilitate the growing number of malnourished children. Improving the management of rehabilitation units by improving screening procedures, management practices and the preparation of effective protocols for the nutritional rehabilitation of young children will be a priority intervention. In the context of rural insecurity, rapid urbanization and population displacement, continued drought in the south and economic adjustment, increased attention has been focused on the need for establishing a nutrition surveillance system that indicates the impact of social, economic and climatic changes on the most vulnerable groups. UNICEF is assisting the Ministry of Health in the development of an integrated nutrition surveillance system to collect and report data on the nutrition level of children under five years old, and low-birth-weight and height-for-age figures for primary school entries. Data will be distributed to decision makers among national planning and emergency authorities. Personnel from 12 sentinel units will be trained in nutrition surveillance techniques, nutrition staff will be equipped and trained in data analysis, interpretation and report writing and a series of seminars will introduce decision makers to the nutrition surveillance system.

Monitoring and evaluation

14. To monitor and evaluate programme implementation and impact, several key activities are planned. Recognizing the ineffectiveness of the Ministry of Health Planning Unit, technical assistance will be provided to establish an evaluation plan that defines impact and outcome indicators and the methodologies by which they will be measured. Key indicators will include area-specific data on mortality, morbidity and malnutrition rates, health service access and coverage rates, and indicators of the extent to which communities benefit from health services. These data will provide a baseline for all impact monitoring during the 1990s. Incorporated within each programme implementation plan will be studies and surveys to assess programme impact on changes in service coverage and use. Programme process monitoring will be undertaken twice a year through the preparation and review of periodic progress reports. These reports, based on joint Government/UNICEF annual plans of action, will permit close follow-up of programme implementation at both national and provincial levels, as well as identify problems and corrective actions and opportunities demanding additional resource or managerial support.

II. ETHIOPIA

U5MR: 261
IMR: 155
GNP per capita: \$130

Child population (0-15 years): 21.5 million
Literacy rate (male/female): not available
Access to health services: 46 per cent

15. In the current country programme approved by the Executive Board in 1988 (E/ICEF/1988/P/L.3), the health and nutrition projects were closely linked operationally and were complementary in their impact on CSD and the welfare of women. Despite the political will and an infrastructure that lends itself to PHC implementation, the strengthening of community health services and the implementation of PHC activities has not been fully realized. This lack of success is mainly due to a shortage of essential drugs at the community and health unit levels and uncertain financial support for programme activities. Among 20,000 community health agents and traditional birth attendants (TBAs) trained thus far, less than 50 per cent function effectively owing to lack of community support. This has been the major hindrance in strengthening community health services. A restructuring of the health services is now necessary following the recent restructuring of the national administration. The previous 16 administrative regions have been restructured into 30 smaller units and there has been a concomitant increase in the number of awraja districts.

AIDS control programme

16. The Government responded to acquired immunodeficiency syndrome (AIDS) in early 1986 by forming a national intersectoral technical task force on the prevention and control of human immunodeficiency virus (HIV) infection and AIDS in collaboration with the World Health Organization (WHO). The task force focused initially on developing a situation analysis and a policy framework to give direction to specific areas of intervention. At a pledging conference, the donor community responded generously by supporting programme activities from March 1988 to December 1989.

17. During this period, activities included strengthening the capacity of the Department of AIDS Control of the Ministry of Health; establishing an infrastructure for effective programme delivery; establishing co-ordinating mechanisms for efficient collaboration among implementing agencies; exchanging experience on the diagnosis and management of AIDS cases; developing guidelines on epidemiological and AIDS case surveillance; developing technical guidelines for blood donors, diagnostic criteria and counselling; establishing screening centres; training physicians, nurses, laboratory technicians and social workers; establishing a data acquisition centre; creating awareness among the general public; developing and disseminating educational materials through a pilot programme in school health; and establishing monthly morbidity and quarterly operational reporting systems.

18. An HIV prevalence survey undertaken by the Ministry of Health with support from WHO, UNICEF and the Swedish International Development Authority (SIDA) in 1988-1989 showed unexpectedly high figures in various segments of the population. An average of 17 per cent of unmarried women in urban areas (24 towns studied) were affected, with the rate reaching 40 per cent in some areas. Some 14 per cent of the male population (truck drivers) and 2.3 per cent of the general urban male population were also affected.

19. This review served as the basis for the preparation of the 1990-1992 programme which has been approved by the WHO Global AIDS Control Programme. The three-year programme budget of \$12 million will establish adequate laboratory screening diagnostic facilities and will support effective social mobilization and health education for increased public awareness for the prevention of exposure to HIV. Because AIDS threatens the gains of CSD, UNICEF involvement aims to keep the population prevalence low and to prevent its spread to mothers, potential mothers and unborn children.

20. Monitoring social mobilization will require the production of guidelines and the organization of conferences, seminars and meetings to ensure full participation by other ministries and mass organizations at the national level, as well as by AIDS control committees in all 30 administrative regions in the country. The programme will promote low-risk behaviour by reaching high-risk groups and schoolchildren (through collaboration with the Ministry of Education) and by raising awareness among the total population. It will ensure safe practices among TRAs by providing them with training and guidelines on protection from HIV, reduce mother-child transmission and prevent unwanted pregnancies by maintaining a team of well-trained and mobile counsellors, producing the necessary educational materials for the counselling team, stationing trained counsellors at the hospitals and other health institutions and equipping them with protective means for distribution.

21. Most activities will be decentralized to regional and, subsequently, to district levels. These will include epidemiological and AIDS case surveillance, laboratory support, pretesting and delivery of information, education and communication (IEC) messages to specific groups, case management and counselling. To maintain a high level of interest, a national conference on health promotion will be held annually to discuss the results of the surveillance and to plan interventions aimed at preventing HIV transmission. The project will be monitored

through monthly morbidity reports, quarterly operations reports which include a description of strategy, monthly financial reports and an annual financial summary.

22. All components will be implemented by the Department of AIDS Control of the Ministry of Health, in collaboration with UNICEF, in accordance with WHO strategies and in close collaboration with education and mass organizations at district and village levels.

23. The project will be monitored through meetings held every two months. Periodic evaluations will be conducted in consultation with UNICEF and WHO.

Revitalization of primary health care

24. This proposal aims to strengthen management capability at the community, awraja, regional and central levels; to develop national policy for the implementation of PHC; to strengthen logistics capacities at the central, regional and awraja levels for the efficient acquisition, storage, transport and distribution of essential drugs and supplies; to undertake analytical and feasibility studies in the area of community financing and revolving fund systems; to provide essential drugs and supplies in order to establish a system of user financing, cost recovery and revolving funds at the community and awraja levels; and to develop monitoring and evaluation schemes for PHC implementation and the phased expansion of nation-wide implementation.

25. In the context of the current UNICEF-assisted country programme, current activities aim to strengthen the management and development of awraja health management teams in rural hospitals, health centres and health stations; and to establish functional referral processes from one level to another. These teams will revitalize community health services through community involvement that will include the services of trained TBAs and community health agents and the construction of health posts. The regular supply of drugs to health institutions and to community health posts will be one of the pillars of the revitalized PHC system. Drugs will be sold at a profit to be established under the guidance of the Ministry of Health in order to generate funds. Awraja task forces, under the guidance of the national task force, will provide policy-level decisions and formulate detailed district tactics for efficient implementation of the PHC strategy. This will include streamlining financial procedures for funds received from the sale of drugs and the use of those funds to establish a revolving system to ensure future supplies. It will also include streamlining procedures for channelling profits into the improvement of PHC programmes in the awraja. WHO/UNICEF Bamako Initiative guidelines will be discussed at this level and a system will be established by the awraja task force that will be relevant to each awraja.

26. Particular attention will be paid to safe motherhood and MCH/family planning services that are provided on the basis of daily integrated services that include immunization and ORT demonstrations at all health institutions. The concept of essential obstetrics will be introduced into MCH/family planning services. Particular attention will be paid to sustained immunization and other services of MCH/family planning. Facts for Life, which has already been translated into Amharic, will provide technical information for family empowerment.

27. Information will be provided and dialogue will be encouraged on environmental sanitation and personal hygiene issues through the promotion of safe waste disposal and personal habits that enhance hygiene and good health.

28. The introduction of community-based growth monitoring and promotion will be based on lessons learned from the WHO/UNICEF-assisted Joint Nutrition Support Programme that was sponsored by the Government of Italy in the Sidamo awraja during 1983-1989. The programme will promote weighing sessions for children under three years old, using these sessions as forums for community discussion of nutrition and for the provision of MCH/family planning services such as immunization and the distribution of ORS and other supplies. Guidelines from the national food and nutritional surveillance project, developed by its national technical committee, will be studied for application in each awraja.

29. The integration with national programmes (which tend to be vertical) will be encouraged through the establishment of appropriate mechanisms for convergence at the level of awraja health management teams. These will include the following programmes: control of malaria and other vector-borne diseases; AIDS control; EPI; CDD; blindness prevention; tuberculosis control; and leprosy control. Each national programme will provide monthly reports to the awraja health management teams. These reports will be compiled in quarterly reports and integration procedures will be discussed.

30. The promotion of intersectoral involvement in PHC will be undertaken under the umbrella of the multisectoral awraja task force/PHC committee. Designated members of the district health management team will encourage interaction at the operational level.

31. The strategy for enhancing the availability of essential drugs includes improving storage facilities and strengthening supply logistics to the awraja level and communities; improving procedures for the selection of essential drugs for each awraja on the basis of disease patterns; improving the local production of essential drugs; and streamlining traditional medicine.

32. The national PHC council, which is multisectoral and includes the participation of mass organizations under the chairmanship of the Prime Minister's office, will provide policy guidelines. A sub-committee, under the chairmanship of the Minister of Health, will constitute the national task force for the revitalization of PHC. The technical secretariat chaired by the Vice Minister will provide technical guidance, implementation follow up and monitoring. Since this PHC revitalization programme involves all departments of the Ministry of Health, the technical secretariat will include heads of all departments who, in turn, will form sub-committees of the secretariat for specific functions.

33. Implementation will begin in 12 selected awrajas and gradually expand to nation-wide coverage. By 1992, at least one awraja in each of the 10 regions will be covered. The project will improve the supply of essential drugs and the availability of funds for improved PHC implementation. It will contribute to the reduction of under-five and maternal mortality rates and enhance the well-being of mothers and children.

III. MALAWI

USMR: 262

IMR: 149

GNP per capita: \$160

Child population (0-15 years): 3.8 million

Literacy rate (male/female): 52/31 per cent

Access to health services: 80 per cent

Primary health care

14. Malawi has one of the highest child mortality rates in Africa and in the world. Although children under five years old comprise only 20 per cent of the population, they account for almost 60 per cent of deaths. Maternal mortality and malnutrition are among the highest in Africa. The PHC programme will focus on the exceptionally high rates of malnutrition and on the main causes of mortality among young children. The programme is comprised of seven projects.

Strengthening of the expanded programme on immunization

15. Since the country reached UCI in 1989, the project aims to increase immunization coverage and maintain it at a level of over 90 per cent. The project will also support the goal of eradicating polio by the year 2000 and eliminating neonatal tetanus by 1995. Vaccines will continue as the largest financial input of UNICEF. Other project needs include further strengthening of logistics, maintenance and management of the cold chain at all levels; providing transportation for EPI outreach activities; and continuing the in-service training of field and supervisory staff in all aspects of EPI. The project will support surveillance and improved health information, supervision, problem solving and routine reporting analysis.

Control of diarrhoeal diseases

16. Diarrhoea is the most common disease among children and fourth among the population as a whole. The project will expand the availability of ORS and reinforce the training of schoolteachers, village PHC committees and other field extension workers in spreading the CDD message to rural households. The project will target the prevention of pollution at village water sources with a mobilization programme and with district technical support and training teams. Another component will promote good water handling practices and personal hygiene. This project will focus on low-cost technologies and community mobilization and directly benefit 60,000 people through the construction of rain water catchment and 52,000 with new shallow wells.

AIDS control

17. By December 1988, 4,168 AIDS cases, or 50.76 cases per 100,000 population had been recorded in Malawi. According to recent official estimates, 21 per cent of the population is HIV positive. As part of the government mass information programme on AIDS, the project will support the introduction of AIDS-related health education in primary and secondary schools through the training of schoolteachers. Training and information materials produced in other countries will be adapted for use in Malawi. Information will be widely disseminated through the mobilization of thousands of peripheral workers.

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Acute respiratory infections

38. In Malawi, 18 per cent of all child deaths reported in hospitals in 1986 were related to acute respiratory infections (ARI). The Ministry of Health will formulate strategies and plans of action for the control of ARI that will include the revision of the training curriculum of all paramedical schools, the preparation of guidelines for the standardization of ARI diagnosis and treatment and the stocking of appropriate drugs. The basic promotion of ARI control activities such as the orientation of health workers, the production of training materials and an adequate supply of drugs for early treatment, will begin in 1990. The project aims to halve ARI-related health centre visits and pneumonia-related infant and child deaths.

Malaria control

39. In 1988, malaria accounted for 30 per cent of all children admitted to hospitals and 19.4 per cent of all child deaths in hospitals. Between 1985 and 1988, there was an increase of 43 per cent in hospital admissions and 85 per cent in hospitals deaths. The project will support the elimination of mosquito breeding sites within one kilometre of villages, promote the use of mosquito nets and establish local matting material for improved protection against mosquito bites.

Health information and training

40. UNICEF has already begun a programme of assistance aimed at the health information system. Efforts to strengthen the programme will include the expansion of information collected for decision-making in the health sector; support for research and analysis of present health service functions; the improved efficiency of PHC as a prerequisite to a sustainable expansion of cost-effective services; and the development of a routine reporting system to increase government monitoring capacities.

Nutrition and household food security

41. The basic cause of malnutrition in Malawi is low household food and economic security. Almost 70 per cent of the rural population is unable to meet its basic nutritional requirements from its own farms. Approximately 30 per cent of households are headed by women, and most of them have less than one hectare of land. Recent experiences of non-governmental organizations (NGOs) demonstrate that the poorest families can double production with well-targeted, low-risk packages of agricultural inputs. This strategy will be tied to a savings and investment scheme for the poorest families, including households headed by women. The project will support and expand NGO initiatives in order to provide nutrition intervention and PHC as envisaged by the Bamako Initiative.

IV. UNITED REPUBLIC OF TANZANIA

USMR: 179

Child population (0-15 years): 12.5 million

IMR: 107

Literacy rate (male/female): 48/18 per cent

GNI per capita: \$250

Access to health services: 76 per cent

Iringa nutrition programme - phase II (1990-1992)

42. Phase I of the Iringa nutrition programme was implemented as an area-based programme for five years from 1983. The region was chosen because it was one of the few regions where recent nutrition surveys had found the frequency of malnutrition to be very high; it has ranges of agro-economic and ecological zones also found in other areas of the United Republic of Tanzania, thus facilitating replicability; and the institutional infrastructure for training and nutrition was well developed.

43. Phase I of the programme aimed to develop capacity at all levels to assess nutrition problems and design appropriate actions. The achievement of this goal was fundamental to the objectives of reducing infant and young child mortality and morbidity, attaining better child growth and development and improving maternal health and nutrition.

44. The success of the programme has been attributed to strong advocacy and awareness-building at all levels, including village campaigns, mass media actions, training, the use of cultural groups and the involvement of leaders; emphasis on monitoring systems that reveal problems at all levels, making them easier to analyse and act upon; improved understanding of the causes of child deaths and malnutrition through better conceptualization and increased understanding of problems by decision makers, parents and community members; support for strengthening services within critical areas such as immunization, diarrhoea and malaria control, and child care and feeding; and the involvement of mobilizing agents in all these activities.

45. The Iringa nutrition programme has been fully integrated into existing administrative structures. Village health committees, together with village health workers, are responsible for programme implementation and follow up. Every three months they weigh all children under five years of age, compile growth monitoring and child death information and discuss the reports with the village councils, which then address the problems that have been identified. The reports are then sent to higher administrative levels so that problems can be identified and supported.

46. Activities aimed at increasing and sustaining capacity-building in the area of nutrition have included increased access to nutrition information, the establishment of village-based nutritional status and death monitoring systems and integrated training. The programme also supports areas identified as crucial for improving the nutritional status of children and women, including MCH, aimed at improving health services, with an emphasis on disease factors responsible for maternal and child malnutrition and infant mortality; water and environmental sanitation to improve household environments and reduce disease-related risk

factors; household food security to improve year-round access to food; child care and development to promote regular and frequent feeding of children; income-generating actions, designed to assist organized women's groups in increasing income to be spent on family welfare; research, focusing on operational research for use in further programme planning and implementation; and management and staff to ensure effective programme management.

47. Specific actions in these areas have evolved in line with the continuous reassessment and re-analysis necessitated by the village-based monitoring system.

48. The evaluation found that there was a marked improvement in the nutritional status of infants and young children and a reduction of child deaths in the programme area. Rates for underweight and severely underweight children in the second quarter of 1988 were 38 per cent and 1.8 per cent respectively, as compared with 56 per cent and 6.3 per cent respectively for the corresponding quarter of 1984. The evaluation also found that in 1987 the prevalence of severe and moderate malnutrition in Iringa villages not assisted by the programme was similar to that found in 1984. A major conclusion was that the transformation of conditions could be directly traced to activities strengthened by the programme.

49. Perhaps of greater importance for the long term, the evaluation found that, with major mobilization of villagers and officials at all levels, nutrition awareness had been enhanced. Through the ongoing monitoring system, decision makers are considering the growth and development of children as an objective in their daily work. With regard to efforts to expand the programme beyond the original 168 villages to the entire region, the evaluation concluded that the approach tested in Iringa could be adapted and transferred to other areas. CSD programmes have already been initiated in six other regions using the basic elements of the Iringa approach. Preliminary results of a study of this expansion confirm both the technical and the financial feasibility of such expansion. Consequently, phase II of the Iringa nutrition programme has been prepared. The programme comprises consolidation activities to sustain what has already been achieved using increased local capability, development interventions to address new areas and operational research for specific problem areas.

50. Sustainability will be achieved through several activities. Systems support and development aims at further increasing the availability of information on nutrition and young child deaths as it relates to the functions of society. Projects will include advocacy, assessment, analysis and planning, management and co-ordination from regional to village levels. MCH activities will also be designed to consolidate, expand and improve health services, with an emphasis on controlling diseases that cause maternal and young child mortality and morbidity. This will be supported by the provision of supplies and equipment, increased development and support to dispensaries, and the production of working manuals and guidelines for each level of care. There will be relevant training of staff, particularly to include family planning, health and nutrition, and sustainability will be promoted through local affordability and operational research on MCH/family planning services.

51. Water and environmental sanitation activities will focus on improving the household environment, with special reference to the child, in order to reduce the risk of disease, especially diarrhoea. Access to clean water through proper maintenance, environmental sanitation and health education will also be stressed.

52. Household food security aims at improving year-round access of the household to food through household food and nutrition planning; the promotion of drought-resistant crops, oilseeds and legumes; and home gardens, the raising of small animals, agroforestry, simple weaning food technologies and the reduction of food losses during storage. The emphasis is on poor families.

53. Mobilization of economic resources is another consolidation programme aimed at supporting production groups, with a focus on women, through income-generating activities. This will be achieved through the expansion of current activities such as oil processing, farming and the processing of agro-products.

54. Overall, phase II will focus on cost-effective interventions directed towards the immediate, underlying and basic causes of malnutrition and disease. The proposed projects and activities are targeted towards a sustained reduction of malnutrition, infant and child mortality and maternal morbidity.

National essential drugs programme

55. The availability of drugs in rural health centres and dispensaries has improved dramatically since the launching of the essential drugs programme supported by UNICEF and the Danish International Development Agency (DANIDA). However, despite this commendable development, the drug situation in the nation as a whole has not improved significantly. This is partly due to the effects of the economic recession and the country's inability to procure sufficient drugs and supplies to satisfy national demand.

56. During phase I (1983-1987), activities focused on establishing the programme and a management structure, systems of distribution, supervision, training and monitoring and evaluation. Special efforts were made by the ruling party and the Government to raise the consciousness of the public about the concept of essential drugs. The crash training programme successfully provided 3,700 health workers with their first contact with the concept. This phase proved that high-quality drugs could be procured at low prices and distributed efficiently to all peripheral health units.

57. By the beginning of the second phase (1988-1990), it was evident that programme consolidation, in terms of procurement, management, distribution and logistics, had been successful. During this period, activities were being geared towards strengthening PHC and introducing an organizational structure that placed the essential drugs programme within the framework of PHC, which includes the following nine projects: PHC management; national essential drugs programme; national drugs policy; medical supplies; health information system and health system research; training and manpower development; village health worker programme; district transport management and supervision; and IEC. The objective of this approach is to strengthen PHC through institutional development at the

national and district levels, intersectoral co-operation, the integration of PHC programmes, increased community involvement, wider coverage of preventive and public health activities and the upgrading and maintenance of curative performance through the provision of drugs and training in the rational use of drugs. In order to implement the above-mentioned strategy, the Government, with the assistance of DANIDA advisers, has focused on the areas of training, PHC, finance/accounting, electronic data-processing management, warehousing and stock control and health planning. UNICEF participation in the essential drugs programme has concentrated on the procurement and distribution of drugs, hospital-based local production, quality control and the supply and maintenance of essential equipment.

58. It was hoped that, in the second phase, the essential drugs strategy would be adopted throughout in the health sector and that it would be able to supply drugs to all health institutions. Because of financial constraints, village health posts were singled out in the first instance for particular attention since it was felt that support at this level would not only serve as a means of legitimizing the village health worker in the eyes of the community, but also ease overburdening at dispensary level. Government and UNICEF documentation, as well as a DANIDA-initiated consultancy report, supported the proposal, but to date no funding has materialized. Given the serious national drug situation, it is hoped that some consideration will be given to extending the programme to this level.

59. Phase III (1991-1992), will see an even greater demand for programme extension. A further devaluation of the Tanzanian shilling and the worsening drug supply situation has placed health care further out of the reach of the majority. The Open General Licence facility has made foreign exchange available for the purchase of drugs, but it has been difficult for the Ministry of Health to mobilize sufficient local currency to provide the necessary cash. Meanwhile, the only drugs available are small quantities received through various lines of credit, import support programmes and private pharmacies. Prices in private pharmacies are extremely high and beyond the reach of most people.

60. UNICEF support for phase III will continue in the areas of procurement, distribution, logistics, local packaging, hospital-level production of pharmaceuticals, local production of laboratory reagents and quality control. The introduction of support for the production of laboratory reagents should be viewed in the context of improving diagnostic capabilities of the health centre and district hospital in an effort to further promote the rational use of drugs and improve health management.

61. The proposal extends the ongoing programme and must be considered within the framework of discussions under way that might require changes during 1991-1992. These relate to the recently completed draft of the national drug policy and to ongoing discussions on strengthening the industrial production of pharmaceuticals locally for the eventual substitution of kit items. The results of these discussions will have definite implications for project activities during 1991-1992. Therefore, the necessary changes will have to be discussed at the appropriate time. Collaboration between the mainland and Zanzibar for the formulation of a joint procurement policy will be encouraged. The overall objective of the national programme is the creation of a comprehensive national

essential drugs system of production, packaging, procurement, distribution and utilization of all drugs for the entire health sector in the United Republic of Tanzania.

V. ZIMBABWE

IMR: 113.

Child population (0-15 years): 4.4 million

IMR: 71

Literacy (male/female): 81/67 per cent

GNP per capita: \$580

Access to health services: 71 per cent

Rural water and sanitation programme

62. Since independence in 1980, the Government of Zimbabwe has placed the highest development priority on the provision of services to the former "communal" lands areas that were neglected by the colonial régime. Among the services that the Government wishes to provide are access to clean water and sanitation and education in hygienic practices. Matebeleland South province has been a priority area for the development of water and sanitation as it is one of the country's driest regions (some areas endure drought for four years out of every five). It also has the country's lowest rural sanitation coverage as identified by the National Action Committee for Water and Sanitation. While some districts in Matebeleland South have been the focus of extensive donor-supported projects in water and sanitation, the districts of Gwanda and Beitbridge have not benefited thus far.

63. In 1988, water-borne diseases accounted for over 25 per cent of all cases reported to health facilities among children under five years old in Matebeleland South, with diarrhoea being the leading cause of death. In the former communal areas, two thirds of all households do not have year-round access to safe water. Women spend up to 10 per cent of their time collecting water, and women and children undertake 98 per cent of all water collection. On this basis, it was determined that improvements in water supply and sanitation would directly benefit women and children by improving their health and nutritional status and by reducing their non-productive work-load.

64. The Government has promoted the development of water and sanitation activities in Matebeleland South province in the past with the support of UNICEF, but activities were curtailed because of dissident activities in 1986. With the settlement of political differences, the possibilities for accelerating activities now exists. In the past, UNICEF had helped the Government to develop techniques for digging deep wells using low-cost technology. This approach has now been adopted by the District Development Fund for replication in other provinces. Through the use of local expertise, Zimbabwe has also developed appropriate technologies in the area of low-cost sanitation, especially the ventilated improved pit latrine. The use of these technologies in Matebeleland South will be extended, while at the same time an intensive system of health education and social mobilization will sustain the programme and ensure its replicability.

65. The objective of the proposed programme for 1990-1991 is to reduce the prevalence of diarrhoea in the target districts of Gwanda and Beitbridge by

10 per cent among children under five years old and to increase per capita water use by 50 per cent, while reducing the time spent by families collecting water by 10 per cent. These objectives will be achieved through an integrated water, sanitation and health education programme to be mounted in two districts of Matabeleland South province. The programme will be co-ordinated at the national level by the National Action Committee for Water and Sanitation and will be implemented at the operational level through existing government structures. UNICEF support will extend and strengthen the infrastructure of various government and non-governmental organizations at district and village levels, and will train and equip village- and ward-based cadres who will assist communities in the establishment and operation of water and sanitation facilities.

66. Programme activities are interlinked and many take place simultaneously at different operational levels. The most critical operational level is that of the village, or community. Land-use plans will be developed to determine the best use of the ecologically fragile land in the two districts, particularly in deciding upon the best areas for cultivation and settlement. On the basis of those plans, discussions will take place to establish community water and sanitation needs. A community committee for water and sanitation (usually a sub-committee of the existing village development committee) will be formed to lead community-based activities. This committee will be trained by extension workers from the relevant ministries, and general community mobilization will also be undertaken through this organization. Health education, the maintenance of water and sanitation structures and community contributions are among the topics to be addressed through village sub-committees. The community committee will also assist district staff in selecting sites for water points and in choosing a volunteer from the community (usually a woman) to be a pump-caretaker. This person will be trained and equipped by the programme. The committee also identifies other persons in the community to be trained as latrine builders.

67. At the ward level (a ward consists of four to six villages), a similar development structure exists, with a ward development committee responsible for all development activities. The ward level is also the lowest level at which government extension staffs are based, and most wards have extension workers who represent the agricultural, community development and environmental health sectors. Most relevant to this programme, each ward has a District Development Fund extension worker responsible for pump maintenance. This person is capable of undertaking all but the most complex pump repairs in the villages and wards. Working together with the environmental health technician, these cadres will guide and support village-based activities.

68. At the district level, the water and sanitation programme will be supported by district development committees, which include district-level representatives of the ministries and organizations responsible for development. For efficiency and economy, most training activities will take place at the district level, under the supervision of the district development committee sub-committee responsible for water and sanitation. The district environmental health technician will undertake water testing in programme villages, and the project will be co-ordinated with other development efforts in the district, particularly those related to

resettlement. The water and sanitation sub-committee will be responsible for contracting borehole drilling services and will undertake local procurement of programme supplies.

69. Activities at the provincial level ensure proper co-ordination of the various district-level water and sanitation activities and support health education through radio programmes and other learning materials. The programme will strengthen and extend the provincial level health education unit in order to produce relevant materials in local languages. The National Action Committee is represented on the provincial sub-committee for water and sanitation, thus the programme is co-ordinated with other national activities.

70. Among the specific achievements of the programme will be the development of six land-use plans; the establishment of 12 village water and sanitation sub-committees; the establishment of three ward water and sanitation sub-committees; the development of two district-level water and sanitation plans; the establishment and equipping of two district-level maintenance teams; the development and pre-testing of six sets of health education materials; the training and equipping of 12 pump-minders; and the training and equipping of 295 village pump caretakers. Service coverage objectives include the drilling or renovation of 45 boreholes; construction or renovation of 250 hand-dug wells; construction of 295 headworks for the boreholes and wells; construction of 50 community and school latrines; and the construction of 2,500 ventilated improved pit latrines for family use. These facilities will provide 33,800 people with water supplies and 12,000 with sanitation services.

71. The programme will be monitored through the establishment of intermediate programme goals and will be broken down to village, ward and district operational levels. The programme management structure will review progress monthly, and corrective action will be taken as necessary. A number of simple indicators for programme progress have been established, and information on these will be collected at the appropriate levels. These indicators include the measurement of continuing performance and the breakdown of existing facilities, as well as the provision of new facilities. Quality control will be monitored at the national level and by UNICEF staff supporting the project. Evaluations will be conducted by the Blair Research Institute, an internationally recognized research institution in the field of environmental health and hygiene.

72. The programme has been developed in co-ordination with the National Action Committee for Water and Sanitation, which co-ordinates all donor-supported activities in this sector in Zimbabwe. Programme activities are thus expected to complement and support, as well as be supported by, the programmes supported by other donors in Zimbabwe. In particular, the programme has been co-ordinated with activities in Matebeleland South by the Government of the Netherlands, the European Economic Community and the Lutheran World Federation.

73. The programme has a total budget of \$750,000 over a period of two years, with a breakdown of \$441,000 for water supply activities, \$141,000 for sanitation activities, \$73,000 for social mobilization and health education and \$95,000 for the training of community workers and programme support.

Estimated annual expenditure

(In thousands of United States dollars)

Country/programme	1990	1991	1992	Total
<u>Angola</u>				
Primary health care	2 720.0	2 760.0	-	5 480.0
Integrated child nutrition	<u>520.0</u>	<u>465.0</u>	<u>-</u>	<u>985.0</u>
Subtotal	<u>3 240.0</u>	<u>3 225.0</u>	<u>-</u>	<u>6 465.0</u>
<u>Ethiopia</u>				
AIDS control programme	1 062.9	1 033.6	1 050.0	3 146.5
Revitalization of primary health care	<u>5 481.8</u>	<u>8 722.0</u>	<u>12 987.0</u>	<u>27 190.8</u>
Subtotal	<u>6 544.7</u>	<u>9 755.6</u>	<u>14 037.0</u>	<u>30 337.3</u>
<u>Malawi</u>				
Primary health care	2 083.0	1 882.0	2 410.0	6 375.0
Nutrition and household food security	<u>117.0</u>	<u>118.0</u>	<u>390.0</u>	<u>625.0</u>
Subtotal	<u>2 200.0</u>	<u>2 000.0</u>	<u>2 800.0</u>	<u>7 000.0</u>
<u>United Republic of Tanzania</u>				
Iringa nutrition programme phase II	1 083.3	2 039.4	1 625.0	4 747.7
National essential drugs programme	-	11 185.3	11 594.8	22 780.1
Zanzibar	<u>-</u>	<u>516.8</u>	<u>474.6</u>	<u>991.4</u>
Subtotal	<u>1 083.3</u>	<u>13 741.5</u>	<u>13 694.4</u>	<u>28 519.2</u>
<u>Zimbabwe</u>				
Rural water and sanitation programme	<u>390.0</u>	<u>360.0</u>	<u>-</u>	<u>750.0</u>
Total	<u>13 458.0</u>	<u>29 082.1</u>	<u>30 531.4</u>	<u>73 071.5</u>



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Programme Committee
1990 session**FOR ACTION**RECOMMENDATION FOR SUPPLEMENTARY FUNDING FOR PROGRAMMES IN
THE WEST AND CENTRAL AFRICA REGION WITHOUT RECOMMENDATIONS
FOR FUNDING FROM GENERAL RESOURCES

SUMMARY

This document contains recommendations for supplementary funding in countries in the West and Central Africa region for which no recommendations for funding from general resources are requested at the 1990 Executive Board session. The project proposals submitted here are aimed at expanding or complementing ongoing programmes in the countries concerned. The Executive Director recommends that the Executive Board approve supplementary funding in the following amounts for the projects listed below, subject to the availability of specific-purpose contributions.

<u>Country/programme</u>	<u>Amount</u>	<u>Duration</u>
	(In United States dollars)	
Burkina Faso	2 068 300	1990-1991
Central African Republic	300 000	1990-1994
Equatorial Guinea	1 538 000	1990-1991
Gambia	1 741 000	1990-1991
Ghana	1 543 000	1990
Niger	4 500 000	1990-1993
Nigeria	10 300 000	1990-1993

Summaries of the individual recommendations follow. A table setting out the planned annual phasing of expenditure for each supplementary funding proposal is given at the end of the document.

I. BURKINA FASO

U5MR: 233

IMR: 137

GNP per capita: \$190

Child population (0-15 years): 3.9 million

Literacy (male/female): 21/6 per cent

Access to health services: 49 per cent

Situation of women and children in Burkina Faso

1. In Burkina Faso, women represent 51.8 per cent of the population and children under five years of age 18 per cent. The health situation of these two groups is a matter of particular concern although communicable and parasitic diseases affect the whole population.

2. The major problems encountered by women are physical exhaustion resulting from daily overwork (14 to 16 hours a day) and poor nutritional status.

3. Several surveys reveal the persistence of malnutrition among women of child-bearing age, and in particular among pregnant and nursing women. Anaemia has a considerable impact on their physical and psychological health and increases their susceptibility to epidemic diseases. A survey carried out in nine provinces in 1987 revealed that on the average 40 per cent of women suffered from anaemia and 10 to 12 per cent of new-born infants had a birth weight of less than 2,500 grams. Xerophthalmia is a serious and widespread disease in some northern provinces. Iodine deficiency disorders are also very prevalent in Burkina Faso. Women have an average of six children, but only 32 per cent of births are attended. The maternal mortality rate is estimated to be 600 per 100,000, or approximately one quarter of all deaths among women. The low school attendance rate and illiteracy among women, in particular, represent a major obstacle to the promotion of health education.

4. Children constitute a group which is particularly vulnerable to infectious and parasitic diseases, malnutrition and diarrhoeal diseases. Some surveys carried out in 1987 and 1988 revealed malnutrition rates of between 22.2 and 63.4 per cent for children under four years of age.

5. The following indicators attest to the gravity of the situation: infant mortality rate 139 per 1,000; immunization coverage 25.7 per cent; access to drinking water 20 per cent; access to health services 49 per cent. Lastly, diarrhoeal diseases affect more than 26 per cent of children under four years of age.

Previous programme of co-operation

6. UNICEF and the Government have worked together on three programmes which were approved by the Executive Board in 1980, 1983 and 1987, in total amounts of \$4,420,000, \$3,939,000 and \$5,800,000 respectively, and focused on the following priority sectors: health and nutrition; village water supply systems; rural development; education.

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7. These sectors of activity are covered in the current 1986-1991 programme, which has had to be extended by two years, until 1992. Priority is given to co-operation at the central level to support national programmes relating to the expanded programme on immunization (EPI), oral rehydration therapy, essential drugs and social mobilization.

8. Past experience emphasizes the need to continue the strengthening of the central planning, monitoring and evaluation structures and to direct programmes to the peripheral level by providing material and financial support for operations, training, management and decentralized planning. During the seminar on social mobilization for health, the political commitment of the President to a new approach to the decentralization of financial management demonstrated the need to undertake activities at the village and department level, while promoting the flow of information.

Social mobilization for the expanded programme on immunization and health

9. Social mobilization was shown to be effective in Burkina Faso in 1984, 1986, 1987 and 1989 during intensified phases of immunization campaigns. It has been characterized in Burkina Faso by an involvement of all political and administrative authorities at all levels and a massive use of the media and of written and audio-visual supports.

10. This project is designed to continue support for modern and traditional communication channels by increasing local production capacities for written and audio-visual supports, mobilizing people through advertising and publicity (competitions, posters, buttons, fabrics printed with logotypes) and using the theatre to convey messages, followed by discussions in national languages. Lastly, the literacy campaigns enable these messages to be disseminated and promote the creation of brochures and comic strips.

11. To reduce the cost of the written and audio-visual supports, the central level has been equipped with an offset printing unit which will be supplemented by a graphics unit in order to enhance the design of such materials. This project received \$488,000 in funding from the Canadian Government and a pledge of \$220,000 in 1990.

12. In order for immunization to become a routine activity throughout the country and to maintain maximum immunization coverage, it is necessary to strengthen the structures through the following actions:

(a) Promotion, at the level of each village, of the registration and monitoring of the target populations with regard to maternal and child health (MCH), EPI and nutritional and growth surveillance;

(b) Strengthening of the logistical supports so as to reach the most remote villages with a view to improving the supply of vaccines and drugs, which would make supervision easier;

(c) Provision of cold chain equipment to all health facilities;

(d) Construction of a cold chain repair workshop, a collection and processing centre for epidemiological data, and a training centre. This component of the project has received Canadian funding in the amount of \$606,000, which covers the construction and outfitting of the national centre.

13. The delay in the collection, transmission and processing of health data, and in feedback, is impeding the monitoring of projects at the central, provincial and local levels. This project is designed to accelerate data collection while limiting the volume of data. It is intended to facilitate decentralized, computerized data processing at the provincial level. This would enable the data to be used immediately, to be transmitted to the central level by radio transceiver, and ultimately to be entered into the data system at the Ministry of Health. This system will also make possible a better management of the vaccine and drug inventories. The project has received \$327,000 in funding from the French Government.

Essential drugs

14. The essential drugs programme is designed to implement the Bamako Initiative and determine its impact on health costs. The training of health personnel from six experimental provinces in financial and drug inventory management is another important component of this project.

15. This component is especially necessary in that the postponement of the next programme to 1992 will create the need for funds to support the Bamako Initiative during 1991.

Control of vitamin A deficiencies

16. This programme is a continuation of a project begun in 1986 in four provinces, which will be extended to three other provinces particularly affected by xerophthalmia. The programme consists of the following elements:

(a) Distribution of vitamin A capsules every four months to children from 0 to 10 years of age and to nursing women, and treatment of xerophthalmia;

(b) Nutritional education in health centres and schools, and social mobilization;

(c) Promotion of market garden crops rich in vitamin A.

Control of iodine deficiencies

17. While the problem of iodine deficiencies clearly exists, its prevalence is not well known. A study begun in November 1989 will provide the basic data. The programme is designed:

(a) To study the prevalence and causes of iodine deficiencies in two different ecological zones (the Sahel and the Sudanian zone).

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(b) To strengthen the capacities of the nutrition laboratory in operational analysis;

(c) To treat the population in the target zones with lipiodol;

(d) To monitor and evaluate the effects of oral versus injectable lipiodol treatment in the two zones in order to determine the advantages and the therapeutic action of the two methods of administration.

Nutritional surveillance

18. This programme will be backed up by the project which the United States Agency for International Development (USAID) plans to carry out in five provinces, beginning in 1991. The project is expected to be extended to other provinces which are ecologically and sociologically different. It consists of the following elements:

(a) Development of a simple system of nutritional surveillance at the village level by communities and village health workers;

(b) Strengthening of the capacities for management, supervision, collection and analysis of nutritional data at the provincial and central levels;

(c) Co-ordination of activities at all levels in the areas of health, agriculture and livestock breeding between the ministries concerned and the various agencies of the Food and Agriculture Organization of the United Nations, the World Food Programme, non-governmental organizations and bilateral co-operation;

(d) Dissemination of information among the population about the problems of nutrition and weaning.

Supervision and promotion of growth monitoring

19. This programme seeks to test in four different provinces an anthropometric monitoring system for children from 0 to 4 years of age. This activity will be undertaken by village health workers who, during advance strategy EPI/MCH circuits, will refer at-risk children to the nursing staff. It will entail the following:

(a) Equipment of the project sites with MCH material;

(b) Provision of support to village women's groups in order to increase their capacities for the production of weaning food;

(c) Dissemination of information among the population about growth monitoring and checking for signs of malnutrition using the full range of modern and traditional techniques of communication;

(d) Strengthening of the monitoring and supervisory capabilities of the health workers responsible for programme sites.

II. CENTRAL AFRICAN REPUBLIC

U5MR: 223

IMR: 131

GNP per capita: \$330

Child population (0-15 years): 1.3 million

Literacy (male/female): 53/29 per cent

Access to health services: 45 per cent

20. The current acquired immunodeficiency syndrome (AIDS) prevention project is designed, within the specific context of the Central African Republic, to set up informational and educational activities in the schools and universities, whose populations are considered to be at high risk.

21. Recent surveys carried out in the major cities of the Central African Republic have shown a rapid increase in the number of persons affected by the AIDS virus. The rate of prevalence in Bangui rose from 2.1 per cent to 7.6 per cent in two years among those 15 to 45 years of age. Among prostitutes, another very high-risk group, the rate was 15.3 per cent in Bambari, the second largest city in the country.

22. According to a recent study, 70 per cent of those affected by sexually transmitted diseases are primary and secondary school pupils or university students, 17 per cent of whom have tested positive.

23. The schools and universities are an ideal environment for awareness-raising among students. Moreover, educational authorities, aware of the high incidence and spread of AIDS, are fully prepared to conduct information and education activities themselves, and to create an atmosphere which encourages dialogue with the students in order to deal with the threat of AIDS.

24. The international community (World Health Organization, United Nations Development Programme, European Economic Community and bilateral co-operation agencies) has rallied to the Government's assistance.

25. In this context, a national programme to combat AIDS has been elaborated. It has three key objectives: (a) to reduce sexual transmission of the virus and its transmission through blood; (b) to improve case management for persons who test positive; and (c) to develop and co-ordinate research on AIDS.

26. The operational goals of this project are the same as those of the national programme to combat AIDS, which are as follows: to reduce the rate of precocious sexual activity; and to integrate information on AIDS into school curricula and into all school and university activities.

27. The strategy includes the establishment of a national committee to combat AIDS, whose initiatives will be followed up at the regional level by PHC committees. The national committee promotes international and bilateral co-operation.

28. It will be necessary to disseminate information among the target population and to educate and communicate with it in order to involve it more fully and gradually steer it towards assuming responsibility.

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29. Training and refresher courses for teachers are a vital component of this programme. Accordingly, educational, informational and communications tools will be produced in conjunction with journalists (press, radio, television), teachers and pupils.

III. EQUATORIAL GUINEA

USMR: 214

IMR: 126

GNP per capita: \$180

Child population (0-15 years): 180,000

Literacy (male/female): not available

Access to health services: 9 per cent

30. After a period of isolation and stagnation that followed independence, Equatorial Guinea entered an era of political tranquillity, which is essential to the country's economic and social development. Yet the country still has serious social problems, and has attempted to strengthen its economic and financial links with the outside world by joining the Customs and Economic Union of Central Africa and the Franc zone. Progress has been appreciable but slow. The country's financial future remains heavily mortgaged, despite agreement by the Paris Club to reschedule the country's external debt, giving it a five-year grace period (until 1991) to put its economy in order.

31. The situation of children and women remains a matter of concern, despite considerable efforts to improve their living conditions. The infant mortality rate (IMR) is very high. IMR declined only from 140 to 128 deaths per 1,000 live births between 1980 and 1987. Infant diseases (measles, diarrhoeal diseases, malaria and respiratory tract infections) continue to kill many children. The environment remains unhealthy.

32. Malnutrition among children under five years old is still high at 30 per cent owing mainly to the high cost of food in relation to wages, limited availability of food and limited access to information on weaning practices.

33. Due to the long period of isolation and the lack of needed resources, the health situation remains precarious. The infrastructure, inherited during the colonial period, has progressively deteriorated. In addition, health professionals are scarce and inadequately trained. Until recently, the system had no credibility because of its lack of equipment and medicine.

34. To assure the rehabilitation of the health sector through the renovation of health centres and the training of personnel, and in view of the Bamako Initiative, the Government has decided to reinforce primary health care (PHC) across the nation.

35. This programme aims to reduce IMR through the development of PHC, attacking the principal causes of infant morbidity and mortality, namely the ailments targeted by the expanded programme on immunization (EPI), which include diarrhoeal diseases, malaria, respiratory infections and low birth weight.

36. This PHC programme, in keeping with the Bamako Initiative, aims to promote community participation in programme implementation, mobilize state structures and non-governmental organizations (NGOs) and promote rationalization of resource utilization. It also aims to increase the capacity of technical services in order to better respond to the needs of the people.

37. Vaccination coverage for children up to two years old remains weak. The programme intends to raise coverage to 80 per cent for children from 0-1 year old during 1990. Immunization activities are under way in 28 existing health centres. Some 20 additional centres are to be established between 1990 and 1994.

38. The sector for the control of diarrhoeal diseases (CDD) will be reinforced, through the supply of oral rehydration salts and through preventive activities.

39. The rapid development of malaria and respiratory infections demands an effort above and beyond therapy, directed more towards prevention.

40. In an effort to lower IMR, care for pregnant women will be strengthened, and the provision of information and education to women will be emphasized.

41. Social mobilization activities should cover all programme components. Co-ordination with other United Nations agencies, bilateral organizations and NGOs will be reinforced in order to strengthen programme impact.

42. An amount of \$1,538,000 is required to assure the implementation of this programme during 1990-1991.

IV. GAMBIA

U5MR: 249
IMR: 144
GNP per capita: \$230

Child population (0-15 years): 3.3 million
Literacy rate (male/female): 36/15 per cent
Access to health services: information not available

Primary health care

43. During the past 10 years, the Gambia has expanded its basic health services and strengthened its PHC infrastructure. Village health services reach about 60 per cent of the rural population, and 10 to 20 per cent of the population live near fixed health facilities. A nation-wide EPI has achieved consistently high coverage (70 per cent fully immunized, including yellow fever), and has significantly reduced the incidence of diseases such as measles, diphtheria, pertussis and tetanus. Nevertheless, IMR remains very high, owing mainly to high perinatal loss, malaria, acute respiratory infections (ARI), diarrhoea and malnutrition. Human immunodeficiency virus infection threatens the situation further. In an effort to lower IMR during the next five years, UNICEF will help the Gambia to consolidate and strengthen the PHC infrastructure, expanding it to cover the entire country.

44. UNICEF assistance to the PHC programme will focus on the following projects: EPI/maternal and child health (MCH); ARI; the reduction of the maternal mortality rate (MMR) and neonatal deaths; malaria control; and nutrition.

Expanded programme on immunization/maternal and child health

45. Since 1981, immunization activities have been integrated into the country network of fixed and mobile MCH clinics operated by field nursing staff. The project will support the Government in: (a) consolidating the infrastructure, improving logistics and providing regular and continuous supplies for the effective delivery of MCH services; (b) gradually increasing total coverage to achieve a sustained level above 85 per cent; and (c) eradicating polio (a sensitive issue after the 1986 polio outbreak) and eliminating neonatal tetanus by 1995.

46. Some 60 per cent of parents are not aware of any of the preventable EPI diseases. Special attention will be given to social mobilization in order to raise public awareness and knowledge of the vaccination programme. Hepatitis B vaccine will be introduced throughout the country. Beginning in 1990, new antigens will be included in the vaccination schedule, such as hemophilus I and pneumococcal vaccines. A solarization scheme currently being expanded will make this crucial aspect of the cold-chain system simpler and more efficient.

Acute respiratory infections

47. The ARI project is an essential component of any strategy that aims to reduce IMR. It has the same priority as that attached to the EPI and CDD projects, since ARI is among the two most prevalent causes of post-natal child mortality. Mortality from ARI in young children is estimated at 10 per 1,000 live births.

48. UNICEF has already committed support for implementation of the ARI project in the Gambia. It aims to: (a) reduce the severity of ARI and the number of deaths from ARI among young children; (b) rationalize the use of antimicrobials and ensure their continuous availability; and (c) develop a cadre of trained personnel who have the knowledge and skills to implement the activities.

49. The central strategy of the project is the early recognition of all pneumonia cases and the timely immunization and application of appropriate therapy. Furthermore, since malnutrition and low birth weight are critical risk factors for pneumonia in children, the project will stress and reinforce education messages on nutrition, MCH and family planning.

Reduction of the maternal mortality rate and neonatal deaths

50. Although the Government has already adopted many of the recommended PHC interventions for reducing maternal mortality, MMR remains high. Since 1981, traditional birth attendants (TBAs) have been trained in sterile delivery techniques and MCH skills, and they routinely administer oxytocics at delivery. Pregnant mothers receive iron folate tablets. Procedures for referral to the first referral level and beyond are in place. UNICEF will support the national health development projects launched in 1988, including the training of TBAs, to increase the coverage of maternal services and to assist the Government in upgrading the services provided by the health referral centres. Project strategies aim to improve antenatal care by promoting the early enrolment of pregnant mothers and to contribute significantly to child survival through the treatment of antenatal problems and the rapid evacuation of obstetric emergency cases.

Malaria control

51. The project aims to control malaria by (a) expanding the use of mosquito nets impregnated with pemethrin to prevent malaria among children in 12 villages located in the MaCarthy Island and Upper River Divisions; (b) strengthening the capacity of the Health Education Unit for Public Education through dissemination of Facts for Life pilot messages, in collaboration with Radio Gambia and the press; and (c) supplying chloroquine and quinine (second line treatment) through a network of community health nurses and rural health centres. UNICEF support will be extended to prophylaxis measures for children and pregnant mothers and improvement of environmental sanitation.

Nutrition

52. Because growth monitoring is an important tool in promoting child health, the Nutrition Unit of the Medical and Health Department started a nutrition surveillance programme in 1984 which covered all children up to five years old in target villages. The children are measured twice a year for their weight and height (Nabano Thinness Chart) by community health nurses trained by the Nutrition Unit. Currently, surveillance is the main activity, and it can be used to measure the effect of most health intervention programmes in the community. The primary goal of the nutrition project is to implement intervention strategies to prevent and manage malnutrition at both community and health centre/hospital levels.

53. Priority will be given to the promotion of adequate feeding practices for infants and young children through the development of educational materials, the production of adequate weaning food using simple household technology and the formulation of a national food and nutrition policy.

54. An amount of \$1,741,000 is required to assure the implementation of this programme during 1990-1991.

V. GHANA

U5MR: 146
IMR: 89
GNP per capita: \$390

Child population (0-15 years): 6.7 million
Literacy rate (male/female): 64/43 per cent
Access to health services (urban/rural): 92/45 per cent

Expanded programme on immunization

55. The main objectives of EPI are: (a) to achieve 80 per cent immunization coverage of all children under one year old and women 15-44 years old by 1990 with vaccines for the EPI diseases and yellow fever; (b) to reduce the incidence of and mortality caused by measles, pertussis (whooping cough), polio, and neonatal tetanus by 80 per cent and tuberculosis by 50 per cent by the end of 1990; (c) to improve data collection and disease surveillance by establishing a regular reporting system from all health facilities; and (d) to ensure that immunization services are provided on a continuous and integrated fashion at all health institutions, and that they are promoted with other PHC components.

56. By continuing mass campaigns until mid-1990, the EPI strategy will address the high drop-out rates for the third dose of combined diphtheria/pertussis/tetanus (DPT) and polio vaccines, accelerate the identification and registration of the target population and intensify efforts to increase static service delivery and regularize outreach services. The current practice in many health institutions is to conduct immunization sessions once a week or on a monthly basis, with an average coverage of three outreach services per month.

57. Training activities will become more regular and will focus on target setting, resource allocation, cold-chain system maintenance, progress monitoring, supervision and evaluation at the point of service delivery. From the end of 1990 and through 1991, training activities will concentrate on refresher courses which will incorporate other PHC components.

58. The multisectoral National Social Mobilization Committee for Child Survival and Development, established in May 1989 for augmenting the technical efforts of the Ministry of Health, will be duplicated at regional and district levels throughout the country by 1990. These committees will form the desired systematic approach to social mobilization. Orientation seminars and workshops will be held at national, regional and district levels to institutionalize the process of social mobilization.

59. In close collaboration with the regional and district social mobilization committees for child survival and development (CSD), each of the 10 regional medical officers will organize a series of two to three mass immunization rounds, each lasting 7 to 10 days. Because of climate variations, each region will work out its own schedule and arrange for the timely delivery of vaccines and other inputs from the Ministry of Health. The Ministry will organize vaccination techniques and training packages for general service or hospital health workers (approximately 5,000 enrolled nurses, staff nurses, medical assistants and midwives throughout the country) to raise the level of trained manpower, especially needed for outreach work. The Ministry of Health will also mobilize all private health

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institutions and medical practitioners not actively engaged in EPI to conduct immunization and provide vaccines and other logistical support.

60. The project will continue to meet all of the country's vaccine requirements as identified by past immunization performance and storage capacity. The Ministry of Health will continue to deliver the vaccine requirements to each regional cold store to ensure proper vaccine management. By the end of 1990, the Ministry will have completed the renovation of the central cold room. At present, all vaccines are temporarily stored at the Noguchi Memorial Institute for Medical Research, approximately 20 kilometres from the EPI headquarters.

61. The EPI headquarters will organize a national cold-chain inventory survey to determine the types of refrigeration units and other cold-chain equipment that need to be replaced and those necessary for health centres under construction. The project will then provide the supplies and equipment to satisfy 25 per cent of the present cold-chain system requirements. In addition, the project will meet 50 per cent of the total national requirement of needles and syringes. The bulk of the project's transport assistance will consist of 100 motorcycles and 250 bicycles to regularize outreach service and improve cold-chain system maintenance at the district level. An additional 10 new vehicles will be procured to facilitate improvements in supervision and programme monitoring, especially in deprived districts.

62. This project is an extension of the initial project approved by the Executive Board in 1986 (E/ICEF/1986/P/L.27). Supplementary funding in the amount of \$1,543,000 is requested for 1990.

VI. NIGER

U5MR: 228	Child population (0-15 years): 3.3 million
IMR: 134	Literacy rate (male/female): 19/9 per cent
GNP per capita: \$260	Access to health services (urban/rural): 99/30 per cent

63. The economic and social development plan (1987-1991) addresses the serious problems of desertification, rapid population growth and food security. The impact of desertification on both the environment and the economy is so potentially devastating that containment and prevention of desertification are national priorities that must be taken into account in all rural development projects. Despite the large surface area, annual food production is far below what is needed. The agricultural sector has been weakened by many years of drought and must be improved.

64. The Aguié District, with about 180,000 inhabitants and a relatively high density of 62 people per square kilometre (compared to the national average of five people per square kilometre) spread over 183 villages and 37 tribes, has one of the country's lowest regional rates of provision of basic social services such as health, education and water and sanitation. The state of agriculture is also becoming a problem. Due to population pressures and the family's gradual loss of farmlands, agricultural yield is on a constant decline (10 per cent per annum). Successive droughts since 1973 have led to a lack of pasture land and a resulting decline of stock breeding.

65. Because of unreliable water points (one water point serves 500 people) and a lack of fire-wood, women are forced to walk about 15 kilometres daily in search of supplies. The district has no more than two rural maternity wards and four dispensaries to serve about 30,000 people. There is no pharmacy, only about five depots, poorly stocked with drugs and far removed from big towns. Malaria and diarrhoea are common diseases among children under two years old, contributing to a high mortality rate of more than 140 per 1,000 live births. Average school enrolment is 20 per cent, and the distance between two schools is generally greater than eight kilometres. Only 22 per cent of all students are girls. In most villages, especially in the north of the district, the majority of people is illiterate.

66. Although the percentage of children under five years old suffering from malnutrition (due to protein/calorie deficiency) varies each year relative to the recorded harvest, it has almost never fallen below 15 per cent (moderate malnutrition). The rate of immunization is very low at 12 per cent, due to too few immunization centres and staff.

67. The Government has requested UNICEF assistance to begin an integrated programme that would provide basic services at Aguié, with a view to meeting the basic needs of the people and contributing to CSD. The programme would benefit 75,000 people in 75 villages.

68. The objectives of the programme are: (a) to promote income-generating activities for 30,000 women (including sheep and cow raising, village mill work and

animal transport), ease their domestic work-load and provide training; (b) to produce enough food for 12,500 families (through seed banks, animal-drawn farming units, plant care centres and nurseries), control child malnutrition and protect the environment, including forests; (c) to improve health coverage through the rehabilitation of the health post and the opening of two new units, the opening of a rehabilitation and nutrition education unit, the training of 180 health workers, the creation of 30 village committees for growth monitoring, the opening of village pharmacies and the provision of water and sanitation; and (d) to improve the literacy rate through the establishment of adult literacy centres, the improvement of science equipment and school gardening instruction.

69. Special emphasis will be placed on the co-ordination of self-sustaining activities to stimulate grass-roots development.

70. The Village Development Council will participate in the identification of all programme activities to ensure that they fulfil village goals and include public participation. It will play a dominant role in ensuring maintenance and cost-effectiveness of all programme investments.

71. At the district level, the Deputy District Commissioner and the Chairman of the Subregional Development Council will closely monitor programme implementation so as to ensure its smooth operation and to encourage the field officers involved in the technical supervision of the various activities. This will ensure that activities are complementary and interrelated in order to achieve the greatest benefit.

72. At the regional level, under the responsibility of the Regional Commissioner, the Maradi Regional Development Council will ensure the necessary programme supervision through the regional technical officers who monitor development activities in the districts. The Regional Commissioner will make the decisions necessary to streamline activities and to co-ordinate them with ongoing projects in the region.

73. In conjunction with the Ministry of Economic Planning, and in consultation with the Regional Development Office and the Territorial Administration, UNICEF will lend its technical and material support in accordance with programme requirements. Evaluation studies will be carried out jointly to determine how the programme has affected living standards and the design of future programmes.

74. An amount of \$4.5 million is required to assure the implementation of this programme during 1990-1993.

VII. NIGERIA

U5MR: 174	Child population (0-15 years): 53.4 million
IMR: 104	Literacy rate (male/female): 54/31 per cent
GNP per capita: \$370	Access to health services (urban/rural): 75/30 per cent

Accelerated immunization programme

75. The accelerated EPI was launched by the Government in October 1984. At that time, an estimated 600 children were dying daily from the six EPI diseases, and immunization coverage levels were estimated at 10 per cent. The objective of the 1984 revised EPI was to build an infrastructure to immunize 80 per cent of pregnant women and children under two years old in order to reduce their mortality rate due to EPI diseases by 50 per cent by 1990. The programme also stressed the development of management and monitoring systems.

76. The high political commitment to EPI, as evidenced by the personal involvement of political leaders in the launching of EPI and the signing of the Universal Child Immunization Declaration, has brought about a rapid increase in service delivery and immunization coverage, as well as enhanced sustainability. Starting with 22 Local Government Areas (LGAs) and about 300 static immunization sites in 1985, the immunization infrastructure was expanded in phases until the end of 1987, when the programme covered all 304 LGAs in some 6,000 static immunization sites. By the beginning of 1989, an estimated 10,000 static immunization sites were operational. The major expansion in coverage occurred during the 1988 national immunization days, which were followed in 1989 by state immunization days. By 1989, 19 of the 21 states had embarked on immunization days for three doses each of the oral polio vaccine (OPV3) and combined DPT vaccine.

77. A detailed external review of the programme undertaken in late 1989 found that the proportion of infants who are fully immunized had risen from 10 to about 60 per cent since 1984. The coverage surveys undertaken in 16 LGAs showed a coverage among infants of 81 per cent for anti-tuberculosis vaccine and 63 per cent for measles vaccine, OPV3 and DPT3. The review team also noted considerable improvement in the quality of the vaccine supply, cold chain system, steam sterilization and community mobilization. UNICEF has been supporting two major laboratories in the country which test the vaccines for quality control. Another significant achievement of the programme is the commitment of the national and state governments to EPI activities. When the Government embarked on immunization acceleration strategies, the activities undertaken were selected to ensure capacity-building for sustainable EPI activities through 1990 and beyond. The system of reimbursable procurement, which started in 1985 and through which the federal and state ministries of health purchase about 35 per cent of imported EPI supplies (including 80 per cent of its vaccines), have made Nigeria the only sub-Saharan African country which buys some of its own imported supplies and equipment. This is the first step towards self-sufficiency in EPI.

78. The 1989 review of EPI identified a number of major weaknesses, including supervision, management, transport, training and disease surveillance. The rapid expansion in services had not always been accompanied by an adequate increase in the availability of the necessary supplies and equipment.

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79. In response to the 1989 review, some innovative approaches will be introduced in 1990, including the adoption of cost-effective strategies such as the mobile team approach for riverine and remote areas. To improve programme management, intensive workshops on EPI micro-planning have been initiated, with the goal of training all LGA managers by the end of March 1990. For the last three years, the major weakness in training front-line immunization workers has been the lack of training materials. Some 53 teaching aids developed in 1984-1986 have been reviewed and of these, 23 new teaching aids were developed. These were being printed at the end of 1989, and will be used extensively for training front-line workers and volunteers in 1990. In addition, national eradication strategies for polio and neonatal tetanus have been proposed.

80. The need for further support to EPI was underscored in 1989 when the Government designated 149 new LGAs, raising the number of basic PHC delivery structures by nearly 50 per cent. For each of these new LGAs, staff must be trained and new cold-chain equipment must be provided. This expansion has increased pressure to upgrade former outreach immunization sites to full-time static delivery sites, with a consequent increase in training and equipment requirements. It is estimated that another 750 static sites will be created in the new LGAs, which must be equipped in 1990. It is estimated that another 750 static sites will be created in 1990 in the existing LGAs as part of the normal increase in service delivery. The federal and state governments have begun to invest additional resources in EPI supplies for the new LGA stores in an effort to enable LGAs to immunize 80 per cent of their eligible populations. However, there are still requirements to be met from external support if the 1990 goal is to be achieved.

81. These additional requirements were identified after the preparation of the bridging proposal submitted to the Executive Board in 1989 (E/ICEF/1989/P/L.8). The funds approved in 1989 for EPI totalling \$15,030,000 from general resources and \$4,100,000 from supplementary funding proved inadequate owing to the enormous acceleration which took place in 1989. All the general resources funds that have been allocated are fully committed, and donors have provided \$3,400,000 of the supplementary funding requirements. With the understanding that a full country programme recommendation will be submitted to the 1991 Executive Board, the present requirements submitted cover the immediate needs from mid-1990 to mid-1991.

82. The Government has requested UNICEF to continue providing essential supplies and logistical support to the national EPI. Other donors, including Rotary International, are also supporting the programme. They provide all the polio vaccine and have allocated \$1.7 million for the procurement of cold-chain equipment. The United States Agency for International Development, which has been providing assistance to EPI mainly in the area of the management information systems, training and evaluation, is likely to contribute further resources in the future. However, even with these contributions, there will be a gap of over \$7 million in the funding of the programme, if it is to be sustainable at the 80 per cent coverage level. The federal Ministry of Health has requested UNICEF to continue supporting the national EPI after June 1991, while the States assume a larger share of state programmes. This will require strengthening the EPI infrastructure in advance to ensure sustainability.

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83. Implementation of the programme will focus mainly on the procurement of supplies and equipment in order to strengthen the capacity of the infrastructure. Electric, gas and kerosene refrigerators will be provided to selected remote and riverine areas. Bicycles, motorcycles and smaller cold boxes will be distributed to strengthen immunization activities at outreach sites. In all cases, adequate spare parts will also be provided. Training, retraining and strengthening supervision will be a major component in the extension of existing programmes. Monitoring disease impact through the use of 120 new sentinel surveillance sites will be initiated, and every state will undertake its own coverage survey of infant immunization activities.

84. An amount of \$7 million in supplementary funding is proposed for support of the accelerated immunization programme during the period 1990-1991.

The prevention of blindness from onchocerciasis

85. Onchocerciasis, commonly known as river blindness, is a chronic, non-fatal disease that causes nodules and other skin lesions, but mainly affects the eyes by causing incurable visual impairment and blindness. It has been estimated to cause blindness in more than 300,000 people in Africa and South and Central America. At least one third of all people with onchocerciasis live in Nigeria. The World Health Organization (WHO) has estimated that up to 20 per cent of all blindness in endemic areas are caused by onchocerciasis. The disease is spread by black flies which breed in fast-flowing rivers, hence the name river blindness. The fear of contracting the disease causes many fertile regions near rivers to be abandoned in favour of less productive areas, which results in overcrowding, lower food production and increased poverty.

86. Although the disease cannot be cured or prevented without the control of the vector, blindness can be prevented through the routine distribution of a long-acting, microfilaricidal drug called ivermectin. The drug must be given once a year to people in infected areas, although it cannot be given to children under five years of age, pregnant women, women who are breast-feeding infants under three months old, people weighing less than 15 kilograms, or people with chronic illnesses.

87. The Government attempted to control onchocerciasis mainly through vector control for nearly 30 years with little lasting effect. Recently, the manufacturer of ivermectin, Merck & Company volunteered to donate supplies of the drug to countries with proper distribution and monitoring programmes. A committee set up by the manufacturer, WHO and other technical experts is screening proposals and providing guidelines to countries interested in using the drug for the control of blindness. The Government has requested UNICEF to assist this programme in four states during the period 1990-1993.

88. The project will cover 12 LGAs in the states of Benue, Oyo, Niger and Bauchi, with a total population of 3 million. The Government plans to distribute ivermectin to these people for a period of 10 years. UNICEF co-operation is designed to initiate the programme in these selected LGAs so that the Government can gain enough experience to expand the programme to all infected areas of the country. Several methods of distributing the drug will be tested (at clinics, mobile teams, house-to-house, at markets, in schools, etc.).

89. Project activities will include: (a) organization and training of onchocerciasis units at the state and LGA levels to maintain control of the drug and its distribution; (b) training of clinic and hospital workers within the Ministry of Health to properly supervise, administer the drug, treat any side effects and maintain records of recipients; (c) training of community workers to prepare census data and mobilize their communities to understand the disease and accept its treatment; (d) provision of vehicles (four-wheel drive, motorcycles and bicycles) for use at state, LGA and health unit levels for implementing, supervising, monitoring and evaluating the programme; (e) provision of supplies and equipment for programme management and laboratory support; (f) training of laboratory staff; (g) distribution of ivermectin to the target populations; and (h) evaluation of programme impact.

90. The drug will be provided free of charge by the manufacturer and will be shipped to the country by UNICEF. The Government will be responsible for the appropriate distribution and use of the drug.

91. Supplementary funds in the amount of \$3.3 million are required to support these activities for the period 1990-1993. The Government of Nigeria will invest \$2 million in these selected areas during the period of co-operation.

92. It is proposed that the Executive Board approve a programme of co-operation for the period 1990-1994 in the amount of \$3.3 million in supplementary funds, subject to the availability of funds.

Estimated annual expenditure

(In thousands of United States dollars)

Country/programme	1990	1991	1992	1993	1994	Total
<u>Burkina Faso</u>						
Health	394.0	474.3	-	-	-	868.3
Nutrition	<u>710.0</u>	<u>490.0</u>	-	-	-	<u>1 200.0</u>
Subtotal	1 104.0	964.3	-	-	-	2 068.3
<u>Central African Republic</u>						
AIDS	100.0	75.0	58.0	37.0	30.0	300.0
<u>Equatorial Guinea</u>						
Primary health care/ Bamako Initiative	690.0	848.0	-	-	-	1 538.0
<u>Gambia</u>						
Primary health care	816.0	925.0	-	-	-	1 741.0

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Country/programme	1990	1991	1992	1993	1994	Total
<u>Ghana</u>						
Universal child immunization	1 543.0	-	-	-	-	1 543.0
<u>Niger</u>						
Integrated basic services	1 264.0	1 318.0	1 074.0	844.0	-	4 500.0
<u>Nigeria</u>						
Accelerated immunization programme	7 000.0	-	-	-	-	7 000.0
Prevention of river blindness	<u>1 038.0</u>	<u>829.0</u>	<u>854.0</u>	<u>579.0</u>	<u>-</u>	<u>3 300.0</u>
Subtotal	<u>8 038.0</u>	<u>829.0</u>	<u>854.0</u>	<u>579.0</u>	<u>-</u>	<u>10 300.0</u>
TOTAL	<u>13 555.0</u>	<u>4 959.3</u>	<u>1 986.0</u>	<u>1 460.0</u>	<u>30.0</u>	<u>21 990.3</u>



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UNITED NATIONS CHILDREN'S FUND
Programme Committee
1990 session**FOR ACTION**RECOMMENDATION FOR SUPPLEMENTARY FUNDING FOR PROGRAMMES IN
THE AMERICAS AND CARIBBEAN REGION WITHOUT RECOMMENDATIONS
FOR FUNDING FROM GENERAL RESOURCES

SUMMARY

This document contains recommendations for supplementary funding in countries in the Americas and Caribbean region for which no recommendations for funding from general resources are requested at the 1990 Executive Board session. The project proposals submitted here are aimed at expanding or complementing ongoing programmes in the countries concerned. The Executive Director recommends that the Executive Board approve supplementary funding in the following amounts for the projects listed below, subject to the availability of specific-purpose contributions.

<u>Country/programme</u>	<u>Amount</u> (United States dollars)	<u>Duration</u>
Central America and Panama:		
Primary health care	38 650 000	1990-1994
Education for development	21 630 000	1990-1994
Children in especially difficult circumstances	7 760 000	1990-1994
Chile	400 000	1990-1992
Colombia	2 300 000	1990-1992
Eastern Caribbean	2 086 000	1990-1994

Summaries of the individual recommendations follow. A table setting out the planned annual phasing of expenditure for each supplementary funding proposal is given at the end of the document.

I. CENTRAL AMERICA AND PANAMA

Background

1. Today, the Central American countries of Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama are facing a deep political and economic crisis which is characterized in particular by a contraction of investment in the social sector and a subsequent weakening of social services. This is further aggravated by the flight of qualified human resources.

2. The evolution of the Central American crisis clearly illustrates the interaction that exists between peace and development. Recession and its social costs nurture political and military tensions, while political and military turbulence considerably aggravate economic problems. These two crises, one economic and the other political, reinforce each other in a vicious circle. Needless to say, mothers and children have been most seriously affected by this degradation.

3. Within the above context, on 7 August 1987, the Presidents of Costa Rica, El Salvador, Guatemala, Honduras and Nicaragua adopted the Esquipulas II Agreement entitled "Procedures for the establishment of a firm and lasting peace in Central America" (see A/42/521-S/19085). Beyond its political and military dimensions, the Agreement was an expression of the will of the Central American countries to collectively approach, as a significant element of the peace process, the region's economic and social development problems. It was also a call to the international community to assist in this endeavour.

4. The General Assembly responded to the call for international support at its forty-second, forty-third and forty-fourth sessions. The General Assembly expressed support for the Esquipulas II Agreement, urged the international community to increase technical, economic and financial assistance to the Central American countries and requested the Secretary-General to promote a special plan of co-operation for Central America.

5. In order to fulfil that mandate, the Secretary-General requested the United Nations Development Programme (UNDP) to co-ordinate the preparation of a Special Plan of Economic Co-operation for Central America (PEC) (see A/42/949). As a part of PEC, a special emergency programme for displaced persons, refugees and returnees (PRODERE) was drawn up to provide assistance to refugees and displaced and repatriated persons, to institute a food assistance programme to alleviate short-term requirements and to institute a special programme of income-earning activities to address recovery and repatriation.

6. UNICEF has responded to this plea for assistance and has substantially increased its capacity to respond to the enormous challenge of survival, protection and development of children in the region.

7. Within the framework of PEC, UNICEF, together with the Governments of the subregion, has identified social development needs for mothers and children that have not been adequately addressed by PEC or PRODERE. The proposed programmes have

been prepared in co-ordination with UNDP (in its capacity as co-ordinator of PEC, the Pan American Health Organization (PAHO), the United Nations Educational, Scientific and Cultural Organization (UNESCO) and other organizations and institutions of the United Nations and inter-American agencies.

8. The three subregional action programmes presented herein reflect the agreement and commitment of the Governments of the countries in Central America and UNICEF to expand and consolidate programmes for child survival, protection and development.

9. These programmes comprise activities that complement and expand upon projects within each of the country programmes. For the Nicaraguan programme, which is being presented to the Executive Board in 1990 (E/ICEF/1990/P/L.16), the subregional programmes represent almost 50 per cent of the total country programme.

Primary health care

10. The integrated primary health care (PHC) programme for Central America is seeking to strengthen UNICEF co-operation in the subregional recovery and development process in order to consolidate gains and prevent further deterioration of key health indicators related to the situation of children and families.

11. Successful implementation of the plan will require the support of an appropriate institutional apparatus at the subregional level and the strengthening of the management capacity of the diverse development sectors. Substantial experience has already been gained in the child survival programme for Central America and Panama, where a subregional ad hoc committee, with a technical secretariat, has been formed. At the country level, national child survival teams have been established under the supervision of a technical co-ordinator. With these experiences of technical co-operation among the Central American countries, similar mechanisms will be established for other programme sectors where national resources will be identified and called upon to play vital roles in their respective spheres of competence.

12. A major programme thrust will be to assist the Central American Governments to better define their health policies and programmes in order to meet the needs of the most vulnerable groups. The PHC programme will be guided by principles of an integrated service approach, the decentralization of programme delivery, a focus on the most vulnerable groups, the active participation of women and emphasis on monitoring and evaluation at the local level to increase capacity for local planning and decision-making.

13. Programme strategies include advocacy to obtain sustainable political support to promote maternal and child health (MCH) issues; organized approaches to health education to ensure popular participation, especially of illiterate audiences and ethnic groups; a strong emphasis on multisectoral approaches; a strengthened focus on the development of local health systems; and improved co-ordination with multilateral and bilateral co-operation agencies.

14. The overall programme goals for the 1990-1994 period are to reduce the infant mortality rate (IMR) by 30 per cent and the under-five mortality rate (U5MR) by 40 per cent in the poorest rural districts bringing them into line with national averages, and to reduce maternal mortality by 50 per cent.

Control of diarrhoeal disease

15. With the goal of reducing U5MR due to diarrhoeal diseases by 50 per cent, and in conjunction with water and sanitation programmes, the control of diarrhoeal diseases (CDD) project will promote oral rehydration therapy, using both oral rehydration salts (ORS) and home-made solutions, with early treatment at home and improved personal hygiene. For training and dissemination purposes, the countries will utilize CDD programme materials from PAHO and the World Health Organization (WHO).

Control of acute respiratory infections

16. Employing an easily applicable and simple methodology developed by PAHO/WHO to rationalize the use of antibiotics through standardized schemes, it is planned to reduce deaths related to acute respiratory infections by 30 per cent. Prevention practices and early interventions will be emphasized to reduce the number of complications. UNICEF will support country efforts to incorporate the training of paramedical staff in the use of antibiotics in areas where institutional health services are not available.

Growth and development monitoring

17. In order to reduce severe malnutrition to 1 per cent and moderate malnutrition by 50 per cent, the project will develop three fundamental interventions: efficient nutrition surveillance systems for qualitative and quantitative analysis of malnutrition and the efficacy of interventions; providing mothers with sufficient knowledge of the importance of growth and development monitoring (using growth charts and simple developmental scales) to facilitate the early detection and treatment of problems; and the promotion of appropriate weaning practices. Nutrition-specific interventions, including the provision of vitamin A and iron and iodine supplementation, are being addressed through other ongoing subregional programmes. As they are phased out, their interventions will be integrated into this programme.

Promotion of breast-feeding

18. New alternatives will be sought to enable all women, especially working mothers, to breast-feed their children for up to four months. Health staff will be the major communicators of information, particularly in countries where pre-natal care and institutional birth delivery coverage are significant. A very important strategy at the local level will be the "mother-to-mother" promotion of breast-feeding. This, as well as other communication strategies (mass media, community participation, social mobilization, commissions, etc.) will form a major thrust of this programme component.

Adequate child-birth and new-born care

19. Traditional birth attendants will be trained to serve as local health promoters in an effort to reduce by 20 per cent a major cause of infant mortality and perinatal and neonatal deaths. They know the practices and habits of their communities, and are in a position to act as community advisors regarding disease and health practices. Major efforts will be directed at strengthening institutional and home care through staff training, the improvement of basic equipment and the development of an efficient referral system to follow up on the timely detection of high-risk cases.

Immunization

20. Immunization coverage of children under one year of age will be improved and maintained. This will be achieved through the following objectives: eradicating polio; eliminating neonatal tetanus; reducing measles cases by 90 per cent; and reaching and maintaining 90 per cent vaccination coverage of children with all antigens and 80 per cent coverage of women of child-bearing age with tetanus toxoid.

Maternal health

21. Special attention will be provided to women's and mother's health. Interventions will aim to increase early pre-natal control and quality of attention, to improve maternal nutrition, to support the early identification of high-risk pregnancies and to promote sex education to prevent early adolescent pregnancies and birth spacing.

Monitoring and evaluation

22. All countries are planning specific activities to improve their information systems in maternal and child care. These improved systems will allow for corrective adjustments in the implementation of the programme. The sentinel site methodology will be further expanded as a tool to assess impact results. Data gathered and used by community volunteers and local government agencies will be made available to the central level for policy and planning. Knowledge, attitude and practice surveys will be undertaken and used for planning and programming purposes.

Social mobilization

23. Subregional and country-specific interventions will promote political will to ensure sustainable solutions in the provision of PHC. This will include technical assistance to Governments to assess the impact of adjustment among the poorest groups and the formulation of policies and programmes within budgetary constraints; the production of educational, promotional and audio-visual materials targeted to various audiences; the promotion of special events and meetings to advocate for the cause of children; increased collaboration with church groups and non-governmental organizations (NGOs) to further advance health services for children and women; the

use of national and international media; and research activities on women's issues to enhance their status, organization, participation and support services.

24. The above strategies, goals and interventions will be implemented in each of the Central American countries, bearing in mind country-specific situations and opportunities. In Belize, closer links will be established between institutional services and community networks, thus fostering the district service delivery capacity. The programme in Costa Rica will develop local health systems in priority areas, using child growth and developmental monitoring as the axis for the promotion of child health. In El Salvador, the Municipal Rescue Plan, which promotes the strengthening of municipalities, will serve as an excellent vehicle to strengthen local health services with community participation. The PHC proposal in Guatemala, while maintaining support to country-wide interventions, will revolve around area-development approaches in the highlands and precarious urban settlements, the expansion of services under the umbrella of community participation, closer involvement of NGOs and intersectoral service delivery. In Honduras, nutrition will be the main intervention to promote the development of local health systems, using the comprehensive network of women's groups and churches to promote MCH in 18 health areas. Nicaragua will base its strategy for the advancement of child health and nutrition issues on a community-based orientation in which the communities themselves will be responsible for their own health with the support of health units and the aid of about 30,000 volunteers. In Panama, while maintaining support to national interventions, the proposed programme will focus on rural and indigenous populations, especially women's and mother's health and the implementation of CSD interventions among these groups.

25. The PHC programme for Central America and Panama will be implemented over a five-year period at a total cost of \$38,650,000.

Education for development

26. The education for development programme is a major initiative towards the goal of "Education for All by the Year 2000" and towards ensuring basic education and development for those children who survive because of CSD interventions. The number of children requiring primary education services in Central America will increase by almost 1 million by 1994, and an additional 1.5 million children currently outside the primary school system will also need schooling. Pre-school services and services for disabled children are minimal in virtually all countries in the region. It is estimated that some 5 million Central Americans are illiterate, principally in Guatemala and Honduras. The programme will develop both formal and non-formal educational opportunities to meet the basic learning needs of pre-school and primary-school-aged children and disabled children, as well as provide essential literacy and life skills for adults. In addition, the programme will promote cost-effective early childhood development programmes related to health activities.

27. Programme actions will be developed through an integrated intersectoral approach and functional links will be established between the various educational projects.

Early childhood development

28. Early childhood development and stimulation activities for children under three years of age will be reinforced, and new strategies will be developed for systematic child monitoring and parent education programmes through the mobilization of community and religious groups and the utilization of communication channels. Pre-school activities for children from four to six years of age will be extended and integrated services will be developed through the promotion of innovative non-formal models to assist transition to the regular school system. Day-care activities will focus on identifying existing solutions, expanding these models and developing alternative services in co-ordination with women's and urban basic services programmes.

Primary education

29. With the objective of increasing primary enrolment in the first four grades, the programme will seek to increase coverage of existing primary programmes, reduce desertion and repetition and promote non-formal programmes for those outside the education system. Programme activities will focus on making educational programmes more responsive to basic learning needs, with a special emphasis on girls and risk groups. Schools closed owing to conflict, children's participation in agricultural production and low parental priority for education are the main causes of high desertion and low enrolment rates. These problems will be addressed through the expansion of distance education by radio and the use of non-formal settings, changes in school schedules and curriculum, and raising the status of teachers in the community and increasing their interaction with parents. For populations outside the formal educational system, innovative strategies and methodologies will be developed, including efforts to stimulate increased use of existing services and to develop non-formal approaches for children in especially difficult circumstances. Specific activities will include the reform of rigid curricula, the incorporation of content related to life skills (based on Facts for Life), the elimination of content that reinforces discrimination and the development of study areas on specific country or ethnic needs.

Childhood disability services

30. Programme activities will focus on the prevention and early detection of disabilities through co-ordination between the health and educational sectors. Emphasis will be given to improving and expanding community-based interventions through the community outreach of existing disability services, the expansion of parent orientation programmes, the development of systematic technical support through mobile units and outreach programmes and the further expansion of appropriate technology components. In order to integrate physically disabled children into existing pre-school and primary school programmes, the programme will address prejudices against these children and support the production and provision of required facilities, such as special desks and chairs. The programme will also attempt to mobilize NGOs and parent organizations and to promote activities where parents work with parents.

Literacy

31. In order to increase education and post-literacy opportunities for, and respond to, the particular needs of drop-outs and adults, particularly women and adolescent mothers, UNICEF will support ongoing actions and will mobilize organizations to initiate or extend literacy programmes within priority areas. Special attention will be given to methodologies for literacy training for adults over 15 years of age and primary school groups currently outside the formal education system. Programme activities will include the development of local and regional literacy campaigns, co-ordination with literacy networks, the development of materials that focus on literacy components, Facts for Life and the needs of the target population and the development of innovative strategies for post-literacy education.

32. UNICEF will support mobilization and advocacy directed to political sectors, decision-making and technical levels. Operational research related to project components such as traditional child-care practices and causes of repetition and desertion will provide the basis for the design of specific interventions. UNICEF will support training for personnel and promoters at the operational levels, as well as technical assistance for the development and dissemination of appropriate curricula that are responsive, flexible and sequential. To share experiences in the region, exchange visits among the countries of Central and Latin America will be sponsored. Skills in the areas of micro-educational planning and institutional capacity-building will be developed through the provision of technical support for the expansion of innovative programmes.

33. The programme will take into account prior UNICEF experience in early childhood development and disabilities programmes, and innovative approaches developed in co-operation with UNESCO, the Catholic Church and NGOs will be promoted to increase the coverage of primary education and literacy services. Each country will emphasize areas of particular need. El Salvador and Nicaragua will implement a full range of educational activities, with a special emphasis on primary education and literacy. Honduras will focus on literacy in rural areas. Guatemala, Panama and, to a lesser extent, Belize will emphasize programmes to reach illiterate indigenous groups, and all countries will increase activities in the area of early childhood development and disabilities. Belize, Costa Rica and Panama will emphasize efforts in early childhood development and disabilities as they have already achieved wide coverage of education services and high literacy rates.

34. The subregional education for development programme, at a total cost of \$21,630,000, will be implemented over a five-year period.

Children in especially difficult circumstances

35. Over a decade of economic depression, political crisis and armed conflicts in Central America have threatened the survival and development of children: 160,000 have died in civil wars; 800,000 to 1 million children under 18 years of age are refugees or internally displaced; and 12 million Central Americans (40 per cent of

the population) live in extreme poverty. Thousands of children have been mutilated, orphaned, abandoned or are living in unhealthy precarious settlements. Child labour has increased in both rural and urban areas as poor families use all their resources just to survive, decreasing their children's access to education and health services. The conditions of institutionalized children have worsened, and increased numbers of street children are threatened by drug addiction, prostitution and delinquency. The risks are greatest for young girls, and in some countries, early pregnancy among adolescents is already a public health problem.

36. The general programme objective is to promote the protection and development of children in especially difficult circumstances in Central America through the mobilization of the public and private sectors and increasing the ability of families, communities and institutional resources to implement sustainable and efficient interventions on a wide scale.

37. The programme will address the needs of the following categories of children in difficult circumstances:

(a) The situation of working children will be improved through access to education, better working conditions and protection of their health. UNICEF co-operation will involve support for participatory investigation, training for counterparts in responsible agencies and for communities;

(b) The needs of street children will be addressed to reduce the abuse and risk that they face and, where possible, to reunite them with their families, to provide them with access to schooling and to facilitate their integration into socio-economic projects. UNICEF support will be provided for situation analyses in order to obtain a more precise understanding of the situation of street children and to effectively target interventions. Technical and financial support will be provided for participatory action-oriented research on street children, in addition to the training of social service personnel. The establishment of open non-institutional shelters will also be supported, together with the development and production of teaching materials;

(c) For the many children affected by armed conflict in the subregion, actions to reduce the effects of psychological trauma will be supported, including the training of community promoters, technical support to psychological support workshops for children and the establishment of child-care centres, playgrounds and recreation areas;

(d) For children who live in institutions run either by government agencies or NGOs, the programme will improve the provision of logistical and technical support for the establishment of procedures for humane and accessible care and support training for administrators and staff of these institutions;

(e) In order to reduce the incidence of abuse and abandonment of children and to protect them, UNICEF will support social mobilization activities with parliamentarians and legislators to promote policy development and the enactment and implementation of legislation with regard to child abuse;

(f) For children affected by natural disasters, institutionalized children and those belonging to indigenous or ethnic groups, special activities will be supported to improve their difficult circumstances through the promotion of preventive and remedial measures, as well as their language and culture through education.

38. Social ministries, other governmental social service agencies, national NGOs, such as the Red Cross, and international NGOs, including Childhope, will be partners and allies in this programme. At the national level, UNICEF will support the development of a national policy for children's protection and development and will promote the ratification and assist in monitoring the implementation of the Convention on the Rights of the Child.

39. In Belize, Costa Rica and Panama, activities will focus on both urban and rural working children and on street children. In Belize, the needs of 800 institutionalized children and an estimated 7,500 abused and/or abandoned children will be addressed.

40. In El Salvador, where 60 per cent of the 500,000 displaced Salvadorans are children under 16 years of age, there are approximately 10,000 street children and 20,000 institutionalized children. UNICEF will work with the public and private sectors, the Church, NGOs, service clubs and volunteers to minimize the effects of armed conflict. Street children and abused and abandoned children will be the targets of special interventions.

41. In Guatemala, the target population are 150,000 children in Guatemala City, Escuintla and the north-western region of the country. It will provide rehabilitation services to children affected by armed conflict, displaced and repatriated children, rural and urban working children and children institutionalized in various public and private homes. The programme will emphasize intersectoral co-ordination to extend the coverage of services for indigenous children and to develop appropriate bilingual and bicultural methodologies.

42. In Honduras, children in difficult circumstances include working children, institutionalized children and street children, who may also suffer from abuse and abandonment. Their needs will be addressed through the development of methodologies for drug-addiction problems, labour abuse, the prevention of acquired immunodeficiency syndrome (AIDS); the training of community and institutional human resources; and national advocacy efforts.

43. In Nicaragua, the crisis has displaced 150,000 children under 15 years of age, made 13,900 children war orphans, forced 6,000 to live in the street and created severe problems for the 18,600 children repatriated after years of exile. Major activities will include technical and community staff training, vocational training for working children, treatment for children with war-related psychological trauma, the development of special education methodologies for street children, the rehabilitation of hurricane-affected children, the prevention of child abuse and social mobilization within the framework of national efforts.

44. At the subregional level, UNICEF will serve as liaison between Central American countries in order to establish a wide network of decision makers and public and private institutions that support the ratification and implementation of the Convention on the Rights of the Child. The subregional component of the programme will include an inventory of human resources, institutions and ongoing child-care programmes and methodologies, thus increasing the countries' abilities with regard to their interventions. Special support will be given to co-operation among Central American countries through subregional technical workshops, field project visits and the dissemination of successful experiences and exchanges among Central American children.

45. The children in especially difficult circumstances programme for Central America and Panama will be implemented over a five-year period at a total cost of \$7,760,000.

II. CHILE

U5MR: 26

IMR: 19

GNP per capita: \$1,310

Child population (0-15 years): 4.2 million

Literacy (male/female): 97/97 per cent

Access to health services (total): 97 per cent

The situation of children

46. Chile has felt the effects of the international economic crisis. As a result of the measures taken to cope with it, there has been a reduction in public spending and less investment in the area of social services. This situation, along with the fall in the purchasing power of many salaries and the high level of unemployment, has caused a deterioration in the living conditions of poor families.

47. The economic situation has contributed to an increase in the number of children in especially difficult circumstances, even though there are few available statistics to assess the scope of the problem. According to official figures, 36 per cent of the population live in conditions of risk or poverty, using as a base the beneficiaries of the most precisely targeted programmes in the government social services network. This implies that 1 million families with more than 550,000 children are living in poverty. Furthermore, 12.4 per cent of the population live in conditions of extreme poverty or indigence, using criteria based on housing and equipment provided by the National Planning Office. However, according to a recent Catholic University publication, based on food consumption, 25 per cent of the population are living in conditions of extreme poverty.

48. Children of poor families have to start work at very young ages and also face problems of abandonment, drug addiction, alcoholism, prostitution and other irregular activities. Various forms of exploitation often impede their proper development.

Programme co-operation, 1989-1990

49. The Executive Board has already approved a \$300,000 planning level for Chile for 1990 (see E/ICEF/1989/P/L.20) to increase advocacy and social mobilization, to ensure that children's needs are included among national priorities for social development; and to promote the concept of child development as an element of human and social development. However, the Government has requested expanded UNICEF co-operation for support services for children in especially difficult circumstances.

Children in especially difficult circumstances

50. The Government of Chile seeks UNICEF assistance to provide support services to children in especially difficult circumstances for their basic needs, to promote their reintegration into the family and the community and to provide support to those families whose children are at high risk of becoming street children.

51. The project is targeted at more than 4,000 street children between the ages of 6 and 15 years, who live in the cities of Santiago, Concepción, Antofagasta, Valparaíso and Temuco. An additional 5,000 children will benefit from vocational training and family counselling to prevent the further deterioration of family ties.

52. Hogar de Cristo, a charitable foundation that has been working in Chile with the poorest sectors, which is particularly concerned about street children will implement the project. Youth groups, as well as other government organizations and NGOs working in this area, will also participate. Specialized training will be given to the staff of the youth groups who are in direct contact with the children.

53. The proposed project will comprise the following actions:

(a) A quantitative and qualitative analysis of the situation of street children in order to produce written and audio-visual materials to create awareness among the public;

(b) The selection, training, organization and implementation of the work of the street educators;

(c) The establishment of a reception centre in each city to provide health, nutrition, recreation and educational services for street children;

(d) The development of psycho-social activities to facilitate the reintegration of children into their own families;

(e) The provision of non-formal education to help these children complete primary education, or to return to the formal education system;

(f) Improving the working conditions of street children, teaching them new skills and helping them to find better jobs;

/...

(g) The promotion of co-ordination between governmental and judicial organizations and NGOs in order to integrate and strengthen the available services for street children.

54. Hogar de Cristo will establish a monitoring system to follow up project implementation. UNICEF will promote exchanges with other countries in the region in order to compare project achievements with similar experiences.

55. This project will be implemented over a three-year period at a total cost of \$400,000.

III. COLOMBIA

USMR: 69

IMR: 46

GNP per capita: \$1,240

Child population (0-15 years): 11.8 million

Literacy (male/female): 82/82 per cent

Access to health services (total): 60 per cent

56. The current country programme for Colombia is for the period 1988-1992. However, the Government has requested that UNICEF expand its co-operation to provide additional support services for children in especially difficult circumstances, to enhance women's development and to increase the provision of clean water and basic sanitation to the poorest areas of the Pacific Coast. These actions will help to create conditions for the eradication of critical poverty.

Children in especially difficult circumstances

57. In Colombia there are 9.6 million children between the ages of 7 and 18 years old, of whom 4.2 million live in absolute poverty and more than 2 million in critical poverty.

58. An analysis sponsored jointly by UNICEF, government agencies and NGOs working in the field of child protection, suggests that some 5,000 children literally live on the streets; these are the street urchins, who have broken away from all family ties. They are the victims of abandonment, lack of protection, abuse and broken homes from the poorest sectors of urban society. The existence of the street urchins is a serious problem in itself, and the problem has been made more acute during last year by the appearance in the capital, Bogotá, of the "streetcleaners", a gang that has added children to their "clean-up campaign", which has already cost the lives of beggars, homosexuals and prostitutes in many cities in Colombia.

59. Recent studies have shown that there are 810,000 working children between 12 and 17 years of age. Some local studies have also shown that children under 12 or even under 10 years of age work in construction, the sugar industry, quarries, coal mines, brickworks, services, the selling of all kinds of goods in all kinds of places, and many combinations of paid labour. The problem is not the fact that children work, but rather the kind of work they are required to do, the physical

conditions involved, exploitation and the risk that these children will drop out from formal education.

60. The Government seeks UNICEF co-operation to promote preventive measures for children and young people at high risk; to support the tutelary functions of institutions and local services; to increase coverage and improve the quality of government and NGO programmes designed to provide support and treatment to minors in especially difficult circumstances; to support improved remuneration and working conditions for employed minors and to generate sources of income for children and young people, individually or in association, as the circumstances may suggest; and to promote the design and adoption of a national policy for the young, including provisions for those in especially difficult circumstances.

61. To fulfil these objectives, the project will develop four general strategies in the cities of Medellín, Cali, Baranquilla, Cartagena, Cúcuta, Pereira, Armenia, Villavicencio, Buenaventura and Florencia, with the active participation of children and their families. The following four strategies are to be complementary and will be developed simultaneously:

(a) The decentralization at the municipal level will be achieved through support to local government institutions and NGOs in their efforts to establish and strengthen their capabilities to analyse the situation of children, and to mobilize resources to provide support services to high-risk minors or those requiring direct attention;

(b) Advocacy will operate at the following three levels: (a) it will be directed at politicians, mayors, directors of institutions, the clergy and teachers to attract individual interest in favour of the young and to promote their rights; (b) it will be directed at institutions that protect and work with the young to keep them informed of the situation of minors living in especially difficult circumstances and to formulate alternative programmes; and (c) it will create public awareness of the situation in which these minors live, of the rights of children and of the need to promote and support the creation of opportunities to reflect and act on the problem;

(c) Social mobilization, including a wide-ranging process of community organization and action, will be promoted so as to provide families and neighbourhood organizations with the opportunity to reflect on the reality of their lives. The formation of youth groups based on districts or communes in the poorest urban areas will be encouraged;

(d) The assessment of services and programmes will be offered to the project beneficiaries, with a view to ensuring greater openness from institutions towards the families and neighbours of young people at high risk. A revolving fund will be set up to support income-generating activities and improved conditions for working minors.

62. This project will be implemented over a three-year period at a total cost of \$750,000.

Social and economic development of women

63. In Colombia, in the last 10 years there has been a growing interest in the study of the participation of rural women in the development process. Although research on the promotion and involvement of women in economic development has not been sufficient, their valuable contributions to the peasant economy can be identified with some degree of precision, as there are 1,364,000 economically active women in Colombia.

64. Statistics on land ownership and credit have shown that 53 per cent of households managed by women are also owned by them. However, they still have limited access to land, credit and technical assistance. Data for the period 1984-1986 show a bias in favour of men in the granting of ordinary loans by Caja Agraria, a financial institution that provides credit to rural areas. For every loan granted to a woman during the period, four were granted to men.

65. The Government has requested UNICEF support to improve the quality of life of 46,629 peasant and indigenous women in 93 municipalities by increasing their productive capacity and income. The project will provide women with technical and administrative assistance, through the regular services of Caja Agraria, to improve their food production capacities; teach rural women about the use and purpose of money, nutrition and home improvements; train officers of the Caja Agraria who will be involved in the project in order to ensure institutional adaptation, and teach them how to handle projects for women; improve the access of rural women to the ordinary lending services of Caja Agraria; support the creation of a guarantee fund to back credit for women who do not have the usual guarantees required by Caja Agraria; and define and implement a process of permanent training, involving bank officers and women credit recipients.

66. This project will be implemented over a period of three years at a total cost of \$550,000.

Water and basic sanitation for the Pacific Coast

67. More than 600,000 people live on the Pacific Coast of Colombia, but the region has only 23 water supply systems, five of which are out of service because of technical faults or design errors. Of the remaining 18 systems, only 7 fully serve the population and none has a system for producing potable water, except in Buenaventura, where a modern system has recently been installed. The 18 functioning systems currently produce untreated water for 313,000 inhabitants, leaving almost 300,000 people with no water supply, 80 per cent of whom are in places with fewer than 2,000 inhabitants. Some 61 settlements in the area have no system at all. Almost 100 communities need individual systems based on the collection of rainwater, as rainfall levels in the area are among the highest in the country (an annual average of 6,000 millimetres). These supply deficiencies undoubtedly explain in part the presence of water-borne illnesses and infections of the skin and gastro-intestinal tract, as reflected in the high IMR (150 per 1,000 live births) compared to the rest of the country (46 per 1,000 live births).

68. With respect to the disposal of excreta, the situation is even worse. There are currently only five sewage systems in the entire region (Buenaventura, Bahía Solano, Itmina, Guapí and Tumaco). Except for Buenaventura, the systems provide only a low level of partial coverage, and have serious technical defects. In the rest of the coastal area, 95 per cent of houses have no means of excreta disposal. The lack of facilities has had a significant impact on the pollution of rivers and major water sources.

69. The situation regarding the collection and final waste disposal is a cause for concern, especially in housing, since refuse is simply deposited outside, where it decomposes. This, in turn, becomes a focus of infection, encouraging the presence of different vectors and generating the spread of diseases.

70. The Government seeks UNICEF support for the provision of safe water to some Pacific Coast municipalities using efficient and low-cost models and to establish a system of basic sanitation to contribute to the reduction of infant mortality and morbidity caused by diarrhoeal diseases. The project will design and implement individual and collective water supply systems and implement a basic sanitary education strategy; guarantee the supply of water to health centres, schools and community welfare children's homes; design and implement methodologies allowing the coastal population to receive training through educational technologies in sanitation and hygiene; guarantee community participation in the construction of the alternatives selected and make the community aware of the need to protect water sources; train the community in the planning, construction, operation, maintenance, administration and evaluation of alternative solutions; reduce the consumption of human energy, especially of women and children, who fetch water to satisfy the needs of the household; and reinforce the health component related to the use of latrines, hygiene habits and the adequate use of ORS.

71. This project will be implemented over a three-year period at a total cost of \$1 million.

IV. EASTERN CARIBBEAN

Better parenting

72. This proposal, serving the Eastern Caribbean islands, including Antigua and Barbuda, Barbados, the British Virgin Islands, Dominica, Grenada, Montserrat, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines and Turks and Caicos Islands, represents an expansion of the programme to upgrade perinatal care and to improve communication and social mobilization for better parenting that was approved by the Executive Board in 1988 (E/ICEF/1988/P/L.14).

73. This programme has been further developed by a better appreciation of the complex causes and consequences of immature parenting on individuals and society. Ongoing work of the UNICEF Caribbean Area Office and related agencies and institutions, new information and greater public recognition of the problems have contributed to this enhanced appreciation.

74. Many factors can affect a human being's physiological and psychological development from the moment of conception, and the health, age and parity of a mother are important factors in determining the health and future of her child. Becoming pregnant before the age of 18 years old significantly increases the health risks to both mother and child. The incidence of births to mothers below 18 years of age in most Caribbean countries is generally regarded as unacceptably high, affecting approximately one fourth of such teenagers.

75. Babies born to mothers in their younger teens tend to be premature, under weight, and are more likely to be delivered by Caesarian section or be still-born. Adolescent pregnancies also present serious risks for the mother, as they are frequently complicated by pre-eclampsia (pregnancy-related hypertension), cephalo-pelvic disproportion and cervical lacerations, which can increase the risk of incurring cervical cancer. Some of the highest incidences of cervical cancer in the world are found in the Caribbean.

76. There is also a need to understand better early childhood development and stimulation and its critical importance in the growth of the child. The knowledge and skills needed to be a good parent are acquired in day-to-day interaction and learning between the generations. The importance of fatherhood and family unity is also a very important dimension. Adolescent parents who are themselves children of adolescent parents almost certainly have very little knowledge of parenting skills such as breast-feeding and mental stimulation and development.

77. A lack of parenting skills has been identified as a major factor in the increasing incidence of child abuse and neglect. Parents who lack the ability and understanding to communicate with their children may resort to physical violence as a substitute for communication.

78. The incidence of child abuse and neglect has other economic and social determinants as well. A number of studies have suggested that many cases of child sexual abuse are related to the unstable unions contracted by the mother, who may perceive her ability to develop relationships with men as providing her only source of income. The abuse of stepdaughters by their stepfathers is one of the more common forms of sexual abuse throughout the Caribbean.

79. An important element of better parenting is the improvement of female self-image through the provision of training in marketable skills, as well as in supplementing formal education if necessary. Many teenagers drop out of school and do not go back if they become pregnant. In a number of islands, illiteracy and unemployment rates are significantly higher among women.

80. The proposed programme will promote and develop better parenting in participating Caribbean countries through key interventions in health, education and skills training, information and the legal domain. An important theme will be to stress the health risks of early parenthood to both mother and child.

81. UNICEF will support the expansion and upgrading of continuing health education programmes; the introduction, use and monitoring of various technologies in perinatal care appropriate to the respective countries; upgrading physical

facilities and providing equipment; and the establishment of and support for a network of technical co-operation among the countries.

82. The programme will seek to educate and motivate adolescent parents to adopt attitudes and practices that will eventually reduce perinatal mortality and morbidity by actively maintaining a positive health status for mother and child, including spacing and delaying future pregnancies to assure the physical, psychological and social well-being of the mother and child.

83. This will be achieved through the preparation and dissemination of relevant programmes through electronic and print media, local artists and theatre groups. Live theatre-based education and radio and television announcements using local calypso music will comprise some of the programme communication channels. Co-operation, including personnel training, will be undertaken with NGOs and service organizations, including churches and family planning groups working with children and adolescents. Curricula on family life education and parenting issues will be developed for use in schools. Parliamentarians and other decision makers will be involved in implementing the necessary changes in the legal system with respect to the rights of women and children.

84. The programme will be undertaken initially in Barbados, Saint Vincent and the Grenadines and Saint Lucia, with progressive expansion. The UNICEF Caribbean Area Office will manage and implement the programme. National and area task forces will co-ordinate the many parties and agencies involved.

85. Foundations for the programme have been well established through the work of the UNICEF Caribbean Area Office over the last 18 months. That work has included the active promotion of children's rights with parliamentarians and other groups, programmes related to teenage pregnancy and child abuse, situation analyses of perinatal care and services and wide-ranging media activities.

86. The themes of the programme have also received public endorsement and support from Caribbean leaders, most recently at the Caribbean Parliamentary Symposium on the Rights of the Child, held in Barbados in 1989.

87. The programme will be implemented over a five-year period at a total cost of \$4,200,000. The Executive Board has already approved \$2,114,000 and the balance of \$2,086,000 is submitted for approval.

Estimated annual expenditure

(In thousands of United States dollars)

Country/programme	1990	1991	1992	1993	1994	Total
<u>Central America and Panama</u>						
Primary health care	6 693	8 517	8 352	7 815	7 273	38 650
Education for development	2 932	5 180	5 580	4 320	3 618	21 630
Children in especially difficult circumstances	<u>1 849</u>	<u>1 567</u>	<u>1 648</u>	<u>1 446</u>	<u>1 250</u>	<u>7 760</u>
Subtotal	11 474	15 264	15 580	13 581	12 141	68 040
<u>Chile</u>						
Children in especially difficult circumstances	150	150	100	-	-	400
<u>Colombia</u>						
Children in especially difficult circumstances	240	257	253	-	-	750
Social and economic development of women	425	63	62	-	-	550
Water and basic sanitation for the Pacific Coast	<u>345</u>	<u>328</u>	<u>327</u>	-	-	<u>1 000</u>
Subtotal	1 010	648	642	-	-	2 300
<u>Eastern Caribbean</u>						
Better parenting	<u>81</u>	<u>402</u>	<u>542</u>	<u>534</u>	<u>527</u>	<u>2 086</u>
TOTAL	<u>12 715</u>	<u>16 464</u>	<u>16 864</u>	<u>14 115</u>	<u>12 668</u>	<u>72 826</u>
